

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03126					03117				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Baltimore			o. STATE		Maryland		
		MARYLAND					b. COUNTY		
							Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Baltimore						Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
39 Murdock Rd.					39 Murdock Rd.				
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)		First		Middle		Last		Month	
Grace		Reese		Agnew				3 3 19 67	
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		9/9/92		74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Home		Maryland		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Orlando Reese					Josephine Lynch				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				
No			213-10-3950		Miss Olga G. Agnew- 39 Murdock Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum with Pelvic Metastases</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>67</u> , to <u>Mar.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>67</u> , and that death occurred at <u>11 P.M.</u> , from causes and on the date stated above.									
22a. SIGNATURE					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
<u>Wm. H. Kammer, Jr.</u>								3/3/67	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
William H. Kammer, Jr.					6011 York Rd.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/6/67		Druid Ridge Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.						DATE MAR 6 1967		<u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE Co. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. LENGTH OF STAY IN 1b Cockeysville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS 15 WARREN Lodge ST. Apt 2					
3. NAME OF DECEASED (Type or print) Baby Girl						4. DATE OF DEATH MARCH 11 1967					
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 11 1967		9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR 11 Months 27 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) BALTO. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME FRANCIS G. ALLSTON JR.						14. MOTHER'S MAIDEN NAME VELMA Faye Godbee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. —		17. INFORMANT MOTHERS CHART - Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 Congenital heart disease DUE TO (b) congenital heart disease DUE TO (c) pulmonary vein stenosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/11 , 1967, to 3/11 , 1967, that (I) (we) last saw the deceased alive on 3/11 , 1967, and that death occurred at 3:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Margaret E. Lang, MD.											
22c. PHYSICIAN'S NAME (Type) MARGARET E. LANG, MD.						22d. ADDRESS		22b. DATE SIGNED 3/11/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF MAR. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City, town or county) (State) Adem's Run, S. Carolina			
24. FUNERAL DIRECTOR John Burm' Sons, Towson, Md.						25a. REC'D BY REGISTRAR MAR 15 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G386 3/20/67

03128

CERTIFICATE OF DEATH

03119

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21212 d. STREET ADDRESS 202 Hollen Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jennie First Middle Last ANAPA				4. DATE OF DEATH Month Day Year March 14, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 23, 1884 9. AGE (In years lost birthday) yrs. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Charles Fazio				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-28-0830		17. INFORMANT Address Mrs. Leonard DeCato, 3208 Northway Dr. Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive heart failure secondary to DUE TO (b) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 11, 1967 , to March 14, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 14, 1967 , and that death occurred at 12:30M , from causes and on the date stated above.							
22a. SIGNATURE Ernesto Hipolito				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 14, 1967	
22c. PHYSICIAN'S NAME (Type) Ernesto Hipolito, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. RECEIVED BY REGISTRAR DATE APR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in day event, within 72 hours after death.

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STATE OF TEXAS

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FOR STATE
MEDICAL DEPT.

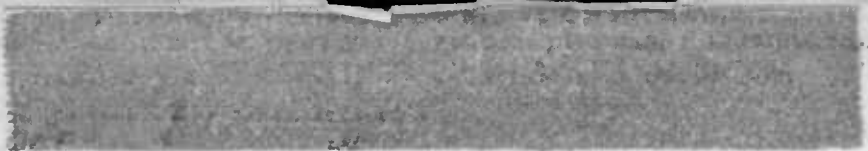
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of this certificate is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03129											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 d. STREET ADDRESS 3420 Dunhaven Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary M. Anderson						4. DATE OF DEATH Month March Day 21 Year 1967					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/89		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Clark						14. MOTHER'S MAIDEN NAME Lena Housner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-07-5551				17. INFORMANT Mrs. Gertrude Marecki Address 7538 Berkshire Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Comminuted fracture of left femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 19 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) fell							
20c. TIME OF INJURY Hour X a.m. 3/2 p.m. 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Baltimore Md.		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Timonium, Md.											
ACTUAL SIGNATURE William A. Pillsbury				EXAMINER'S NAME (Type) William A. Pillsbury				DATE SIGNED 3/21/67			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-1967		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel				22d. LOCATION (City, town, or country) Baltimore, Maryland			
23. FUNERAL DIRECTOR Lilly & Zeiler Inc.						24. REC'D BY REGISTRAR 23 1967					
24b. REGISTRAR'S SIGNATURE Charles Judge											

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>1215 Cedarcroft Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>D.</u> Last <u>Anello</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1890</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Delligo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Anello</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Antonio Anello</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Ischemic cardiac</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-67</u> , 19 <u>67</u> , to <u>2-14-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-14-67</u> , and that death occurred at <u>10:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence M. Serra</u>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence M. Serra, M.D.</u> <u>11 East Chase Street,</u>		22d. ADDRESS <u>Baltimore, Maryland 21202</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03131		Item #2d Film #3307 4/4/67 pg				03122			
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>03.1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. Joseph Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>10 Park Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET M. ATKINSON</u>			4. DATE OF DEATH Month Day Year <u>3 28 1967</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George GRINDELL</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN SHARON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. MARGARET A. BRADY</u>		Address <u>10 Park Dr. #28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis C.V.D.</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>J.C. Pound</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J.C. Pound</u>				22d. ADDRESS <u>3325 Frederick Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>			
24. FUNERAL DIRECTOR <u>E.S. MacNabb</u>				ADDRESS <u>301 Frederick Rd #28</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03133

03133

ST. Louis, Mo.
May 1, 1904
Mr. George Grindell
Hosch
Chicago, Ill.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. E. Jones
Secretary
ST. LOUIS, MO.
May 1, 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03132

CERTIFICATE OF DEATH

03123

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21218</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>			d. STREET ADDRESS <u>2327 N. Charles St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary V. BAGLEY</u>			4. DATE OF DEATH Month Day Year <u>March 18 19 67</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1910</u>		9. AGE (In years last birthday) yrs. <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>NO NE</u>			17. INFORMANT <u>Family Records</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> DUE TO <u>pulmonary thrombo-embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <u>she</u> (this hospital) attended the deceased from <u>March 6</u> , 19 <u>67</u> , to <u>March 18</u> , 19 <u>67</u> , that <u>she</u> (we) last saw the deceased alive on <u>March 18</u> , 19 <u>67</u> , and that death occurred at <u>12:15 am</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Reynaldo Orjuela-Gomez, M. D.</u>			22b. DATE SIGNED <u>March 18, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela-Gomez, M. D.</u>			22d. ADDRESS <u>7620 York Road, Towson 4, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>20 MAR. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MAY'S CHAPEL CEMETERY LUTHERVILLE, MD.</u>	
23d. LOCATION (City or Town) <u>Towson, Md.</u>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <u>John Burnham Sons, Towson, Md.</u>			25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>gcharles Judge</u>			25c. DATE		

03153

3532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03133						03124					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			BALTIMORE			a. STATE			MD.		
			MARYLAND			b. COUNTY			BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CATONSVILLE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			CATONSVILLE		
									03-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
21 DUNMORE RD.						21 DUNMORE RD.			YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
EDWARD			E. BAILEY			MARCH			11 19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		SEPT. 1, 1909		57 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
CLAIMS CHECK				J.S. ADM.		MD.			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
EDWARD BAILEY						ANNA EDENFIELD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No						Mr. Dorothy C. Bailey - 21 Dunmore Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:									15 mos.		
IMMEDIATE CAUSE (a) Hodgkins Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 65, to 3/11 19 67, that (I) (we) last saw the deceased alive on 3/11 19 67, and that death occurred at 7:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE								22b. DATE SIGNED			
John H. Toohy								3/13/67			
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS			
JOHN H. TOOHY, M.D.								ST. AGNES HOSP., BALTO MD 21229			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			3-14-67		Lorraine Park Cemetery			Woodlawn Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Jules Cravangh B. Catonsville, Md						MAR 15 1967		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

M

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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #13 & 14 Film #G387 3/27/67 pc

03134

CERTIFICATE OF DEATH

03125

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Baltimore b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2MO	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2034 Read Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LULA A. BAILEY		4. DATE OF DEATH Month 3 - Day 25 - Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/1881
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaiah Bailey		14. MOTHER'S MAIDEN NAME Frances S. Young Kephart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. Belva I. Tiedemann		Address Same as 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X <input checked="" type="checkbox"/> Chronic Bronchopneumonia DUE TO (b) <input checked="" type="checkbox"/> Chronic Brain Syndrome DUE TO (c) <input checked="" type="checkbox"/> Chronic Urinary tract Infection		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD severe Osteoarthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-29- , 19 66 , to 3-25- , 19 67 , that (I) (we) last saw the deceased alive on 3-25- , 19 67 , and that death occurred at 11:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Cervero		22b. DATE SIGNED 3-25-67	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS 2629 Liberty Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/67	
23c. NAME OF CEMETERY OR CREMATORY Louden Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR J. I. Stansbury		25a. REC'D BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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INSTITUTE OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03135					03126				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bentley Springs</u>			c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bentley Springs</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —					d. STREET ADDRESS —			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>R. Baker, Jr.</u> Middle <u>R.</u> Last <u>Baker, Jr.</u>			4. DATE OF DEATH <u>Mar. 27</u> 19 <u>67</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28/1918</u>		9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Fabricator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard R. Baker, Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Phillippiance Hoffman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>				16. SOCIAL SECURITY NO. <u>218-01-1641</u>		17. INFORMANT <u>Mrs. Janet A. Baker, Bentley Springs</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 27</u> , 19 <u>67</u> , to <u>Mar. 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar. 27</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>A. M. France</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>					22d. ADDRESS <u>Parkton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Stablers Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Parkton, Md.</u>			
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom, Pa.</u>					25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

Baker, W.

58/1818 H

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9/11/99, 10:00

Mrs Janet A Baker

130/67

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard c. LENGTH OF STAY IN 1b 30-4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ft. Howard Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1751 E. Oliver Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANTONE BARANOSKI		4. DATE OF DEATH Month March Day 12 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-98	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 12 Days 19	11. IF UNDER 24 HRS. Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME _____		14. MOTHER'S MAIDEN NAME MARY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		
16. SOCIAL SECURITY NO. 220 30 6436		17. INFORMANT JOS. BARANAUSKAS		Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral injury 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on sidewalk				
20c. TIME OF INJURY Month, Day, Year Hour 9:00 p.m. 2 17 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore --- Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 3/14/67		22. DATE SIGNED 3/14/67
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM		23d. LOCATION (City or Town) (County) (State) Ft. Howard Baltimore Md
24. FUNERAL DIRECTOR T. Fisher - 1930 Eastern Ave.		25a. REC'D BY REGISTRAR APR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

08137

08138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03137						03128					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>BALTIMORE</u>						a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Paper Mill Rd. Thoeny, Md.</u>					
c. LENGTH OF STAY IN 1b <u>2 Hours</u>						d. STREET ADDRESS <u>GEN. PAPER MILL RD. 21131</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATOR BALTIMORE MEDICAL CEN.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Wm. LUTHER</u>						4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-29</u>		9. AGE (in years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD. SPEC. WIRE CO.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>PHOENIX, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORMAN BARRETT</u>						14. MOTHER'S MAIDEN NAME <u>PEARL BYRD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>215-24-5503</u>		17. INFORMANT <u>MRS. SADIE P. BARRETT PAPER MILL RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery arteriosclerosis</u> (c) <u>Coronary artery arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March 27, 1967</u> , to <u>March 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 27, 1967</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Manuel A. Gongon</u>						M.O. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/30/67</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore County Maryland</u>		
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

03187

03187

Genus *Orthocentrus*
Faint *Orthocentrus* description

X

MAHLE A. GONON
Genus *Orthocentrus*
Faint *Orthocentrus* description

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03138

CERTIFICATE OF DEATH

03129

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 731 N. Collington Avenue	
3. NAME OF DECEASED (Type or print) First Joseph W. Middle BASE Last BASE		4. DATE OF DEATH Month March Day 3 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-1-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMAN		10b. KIND OF BUSINESS OR INDUSTRY U. S. mail	9. AGE (In years last birthday) yrs. 63
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK J. BASE		14. MOTHER'S MAIDEN NAME Rose Stredcek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-44-3418	
17. INFORMANT Mary F. Base		Address 731 N. Collington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the colon DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1538		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) February		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 8:20 P.M. on March 3, 1967 from causes and on the date stated above.			
22a. SIGNATURE Dr. Eduardo M. Canilang M.D.		22b. DATE SIGNED 3-3-67	
22c. PHYSICIAN'S NAME (Type) Eduardo M. Canilang MD.		22d. ADDRESS 7620 York Road, Baltimore 21204 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-7-67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Philip E. Czech		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 1211 Chesaco Ave.		DATE MAR 7 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03139

CERTIFICATE OF DEATH

03130

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY Catonville b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNK. c. LENGTH OF STAY IN 1b UNK. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miller Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 535 Carey Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY HERNDON BASKERVILLE		4. DATE OF DEATH Month 8 Day 13 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-1882
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) OXFORD, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DRURY HERNDON		14. MOTHER'S MAIDEN NAME SALLIE PATTERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. UNK.	
17. INFORMANT Dr. Mary N. Brooks		Address 535 N. Carey Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Hemorrhage DUE TO (c) Hypertensive Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH Day Week Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-1-1967 to 3-13-1967 , that (I) (we) last saw the deceased alive on 3-12-1967 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Hunt M.D.		22b. DATE SIGNED 3-15-67	
22c. PHYSICIAN'S NAME (Type) RICHARD H. HUNT		22d. ADDRESS 1607 Mulberry St Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-16-67	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	23d. LOCATION (City, town or county) (State) Arbutus, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Morton & Dyett F.H.		25a. REC'D BY REGISTRAR 15 MAR 1967	
ADDRESS 1701 Laurens St.		25b. REGISTRAR'S SIGNATURE Charles Judge	

08138

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Sanoville

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03140

CERTIFICATE OF DEATH

03131

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 304			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 2647 WILKINS AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VINCENT DE PAUL BEATTY				4. DATE OF DEATH Month Day Year MARCH 31 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 5, 1901		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY <i>Paper Box Factory</i>		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM LEO BEATTY				14. MOTHER'S MAIDEN NAME MARY MC CALL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 216 07 49 78		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) BRONCHOGENIC CARCINOMA WITH METASTASIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from MARCH 23 , 19 67 , to MARCH 31 , 19 67 , that (1) (we) last saw the deceased alive on MARCH 31 , 19 67 , and that death occurred at 3:40 A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/13/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i>				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS COWAN FUNERAL HOME 901 Hollins St. Baltimore, Md.							

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MAINTAINED

PAINTING

PAINTING

8 DAYS

PORT HONOR

SON'S MOTHER'S NAME

VETERAN'S ASSOCIATION HOSPITAL

HEALTHY

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ALWAYS

EXPERIENCE, 1900

WHITE

HAIR

WITNESS, MARRIAGE

LEADER

WENT TO CAMP

WILLIAM 120 YEARS

AT HOSPITAL

WAS ON 19 TO 1910 HONOR HONORS FOR SERVICE, MARRIAGE

WAS

WAS

PROSECUTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03141					03132						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk, Maryland						
c. LENGTH OF STAY IN 1b 27yr5mth17dys					d. STREET ADDRESS Route 3- Box 44 -Holabird Ave.						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Mathias Bedrunka					4. DATE OF DEATH Month March Day 12 Year 1967						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1883		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer					10b. KIND OF BUSINESS OR INDUSTRY brewery		11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Mathaus Bedrunka					14. MOTHER'S MAIDEN NAME Theresa Freisler						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-01-4455-A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) Parkinsonism - Systolic hypertension										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that no (this hospital) attended the deceased from Sept. 25, 1939 , to March 12, 1967 , that we (we) last saw the deceased alive on March 12, 1967 , and that death occurred at 5:45 M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Anthony J. Young</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-13-67				
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.					22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/17/67		23c. NAME OF CEMETERY OR CREMATORY ST. John's Cem		23d. LOCATION (City, town or county) (State) HOWARD Co. Md.				
24. FUNERAL DIRECTOR E. S. MacNabb					ADDRESS 301 Frederick Rd Balt 28 Md		25a. REG'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

03192

03192

STATIONARY ENGINE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03142 1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN MD 3-7-67 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					03133 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 580 Frederick Rd d. STREET ADDRESS Baltimore 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) PAUL		First FOSTER		Middle BELL		Last		4. DATE OF DEATH Month 3 Day 4 Year 1967	
5. SEX M		6. COLOR OF RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/27/14		9. AGE (in years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. BELL					14. MOTHER'S MAIDEN NAME VIRGINIA CARL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (no), or unknown)				16. SOCIAL SECURITY NO. 412-01-2488		17. INFORMANT Address Mrs. Francis Kearney-580 Frederick Rd. Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, PULMONARY 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 mo									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 66 to 3-4 , 19 67 , that (I) (we) last saw the deceased alive on 3-4-67 , and that death occurred at 1:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer						22b. DATE SIGNED 3/4/67		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-7-67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.						25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00142

Baltimore County

Mount Wilson

Mount Wilson State Hospital

W. H. Wilson

Director

W. H. Wilson

Mount Wilson State Hospital

W. H. Wilson, M.D., Superintendent, Mount Wilson, Maryland

MAR 8 1937

03143

CERTIFICATE OF DEATH

03134

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>	
c. LENGTH OF STAY IN lb <u>3yrs</u>		d. STREET ADDRESS <u>524 Stevenson Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>524 Stevenson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Lee Bennett</u>		4. DATE OF DEATH Month Day Year <u>MARCH 10 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/17</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Fred H. Waters</u>		14. MOTHER'S MAIDEN NAME <u>Ada Waters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Arthur Bennett</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration & Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Undifferentiated Carcinoma origin</u> DUE TO (c) <u>undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>Mar 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 10</u> 19 <u>67</u> , and that death occurred at <u>12:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Th. Fereiot III</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/10/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Thomas N. Fereiot III</u>		22d. ADDRESS <u>2045 York Rd Timonium</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY ME</u>	23d. LOCATION (City or Town) (County) (State) <u>COCKEYSVILLE MD.</u>
24. FUNERAL DIRECTOR <u>JOHN BURNS Son's</u>		ADDRESS <u>Towson</u>	25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03144

CERTIFICATE OF DEATH

03135

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		14-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUTH C. BENNETT		4. DATE OF DEATH Month Day Year MARCH 17 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1894
9. AGE (In years last birthday) yrs. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE	
11. BIRTHPLACE (County & State, or foreign country) HAVERHILL, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CASWELL		14. MOTHER'S MAIDEN NAME BERTHA LARRAWAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give year or dates of service) NW 1		16. SOCIAL SECURITY NO. 214 22 31 42	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X MULTIPLE MYELOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 3/6/67 , 19__, to 3/17/67 , 19__, that (X) (we) last saw the deceased alive on 3/17/67 , 19__, and that death occurred at __ M, from causes on and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/20/67	23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	23d. LOCATION (City or Town) (County) (State) near - Chestertown, Md.
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR J. Willis Wells	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 20 1967	
25d. ADDRESS 405 HIGH STREET, CHESTERTOWN, MD.			

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03145

CERTIFICATE OF DEATH

03136

1. PLACE OF DEATH BALTIMORE COUNTY 204 E. Joppa Rd. Hampton House Apt 1014 MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Towson d. STREET ADDRESS 204 E. Joppa Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Towson		c. LENGTH OF STAY IN 1b 5 Yrs.		6. DATE OF DEATH March 22 1967		7. DATE OF BIRTH June 20 1893	
3. NAME OF DECEASED (Type or print) Edward Hayes Benson				4. DATE OF DEATH March 22 1967		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20 1893		9. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (County & State, or foreign country) Cockeysville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josuha E. Benson				14. MOTHER'S MAIDEN NAME Katie Hayes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW. I II 220 46 5358		17. INFORMANT Address Mrs. Edward Benson 204 E. Joppa Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary artery occlusion DUE TO (b) arteriosclerotic heart disease DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 3/22/67			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 10:15 AM, 3/22/67, from the causes and on the date stated above.							
22a. SIGNATURE J. Hamed MD		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/22/67	
22c. PHYSICIAN'S NAME (Type) JAMSHID HAMED MD		22d. ADDRESS 204 E. JOPPA RD TOWSON MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Jessups Cockeysville		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd.				25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
ZDM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03146
CERTIFICATE OF DEATH
03137

1. PLACE OF DEATH a. CDUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1230 North Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>1230 North Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred K. Berger</u> First Middle Last 4. DATE OF DEATH <u>3/29</u> 19 <u>67</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/28/08</u> 9. AGE (in years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry F. Blanner</u> 14. MOTHER'S MAIDEN NAME <u>Frieda Bergerow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>216-20-6768</u> 17. INFORMANT <u>George R. Berger</u> Address <u>1230 North Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deathly Melancholia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>March</u> 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above. 22a. SIGNATURE <u>John C. Healey</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. John Healey</u> 22d. ADDRESS <u>134 Francis Ave.</u> 22b. DATE SIGNED <u>3/30/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/1/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Linden Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03160

03160

03147

CERTIFICATE OF DEATH

03138

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4218 Kensington Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John J. Biemiller, Sr.		4. DATE OF DEATH Month March Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1902
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Biemiller		14. MOTHER'S MAIDEN NAME Elizabeth Jordan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-8715	
17. INFORMANT Anna M. Biemiller, 4218 Kensington Road		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO ARTERIOSCLEROTIC C.V. DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1201 (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12 , 19 36 , to 3/16 , 19 67 , that (I) (we) last saw the deceased alive on 3/15 , 19 67 , and that death occurred at 3:41 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Thomas E. Roach		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas E. Roach		22d. ADDRESS 5550 Baltimore National Pike, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR MAR 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03148

CERTIFICATE OF DEATH

03139

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson	c. LENGTH OF STAY IN 1b 1 year 10 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Perey Middle Kritzman Last Blair	4. DATE OF DEATH Month 3 Day 21 Year 1967		
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-2-1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Wood	
11. BIRTHPLACE (County & State, or foreign country) md. (Wash. Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Blair		14. MOTHER'S MAIDEN NAME Alice Tosten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 170-12-7889	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Had advanced pulmonary tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 26, 1965 , to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 7 p.m. from causes and on the date stated above.			
22a. SIGNATURE W. M. Newcomer		22b. DATE SIGNED 3.21.67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/25/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.
24. FUNERAL DIRECTOR Robert M. Martin Rest Haven Funeral Chapel		25a. REC'D BY REGISTRAR MAR 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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CERTIFICATE OF DEATH

03140

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN lb <u>1 Day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSP.</u>		d. STREET ADDRESS <u>7239 PARK HEIGHTS AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>ABRAHAM BOGART BOGARTZ</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	9. AGE (In years last birthday) <u>68</u> yrs.
13. FATHER'S NAME <u>Simon</u>		14. MOTHER'S MAIDEN NAME <u>ANNY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>051-07-0759</u>	
17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }		INTERVAL BETWEEN ONSET AND DEATH <u>ROUES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>67</u> to <u>3/19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>67</u> , and that death occurred at <u>3:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Mariano A. Tolentino</u> M.D.		22b. DATE SIGNED <u>3/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIANO A. TOLENTINO</u>		22d. ADDRESS <u>5731 SIMMONDS AVE., BALTIMORE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/21/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAR SINCI</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>SYLVAN S. LEWIS & SON, INC. - BARRISON, MD</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAKING

EXTRACT

EXTRACT

7-31 THE HONORABLE

MEMORANDUM

DOCKET

7-19-78

M W

CHART

ROUTE HYPOCAUSTIC INFECTION
GERMAN AT TROPIC DISEASE



Wm. C. Threlkeld
HARRING A. THRENTING 231 SHIMMERS
7/19/78

7/19/78

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03150

CERTIFICATE OF DEATH

03141

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First Philomena Middle S. Last Bohn		4. DATE OF DEATH Month March Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-84
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William		14. MOTHER'S MAIDEN NAME Theresa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-6189	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypostatic pneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 9-15-66 , 19 66 , to March 8, 19 67 , that (X) (we) last saw the deceased alive on March 8, 19 67 , and that death occurred at 1:10 P. M, from causes and on the date stated above.			
22a. SIGNATURE <i>Evelio A. Felipe, M.D.</i>		22b. DATE SIGNED 3-8-67	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) Balto.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25a. REC'D BY REGISTRAR DATE MAR 15 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. ADDRESS 6500 York Rd. 21212	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03151						03142					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Balto</i>						b. COUNTY <i>Baltimore</i>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
2670 Hillcrest						2670 Hillcrest					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <i>SOPHIA M. BRANDT</i>						Month Day Year <i>March 5 1967</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/11/19</i>		9. AGE (In years last birthday) <i>47</i>		10. IF FUNER 1 YEAR IF FUNER 24 HRS.	
								Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
<i>Housewife</i>								<i>Baltimore</i>			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<i>Henry Hecker</i>						<i>Catherine Weisbrot</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						<i>Daughter</i>		<i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>											
4500 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19						While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>10 Sept</i> , 19 <i>66</i> , to <i>5 Mar</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4 Mar</i> 19 <i>67</i> , and that death occurred at <i>12 M</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Howard E. Gorman</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6 March 67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard E. Gorman</i>						22d. ADDRESS <i>8604 Harford Rd Balto Md 21234</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<i>Burial</i>			<i>3/7 1967</i>			<i>Immortal</i>			<i>Balto Md</i>		
24. FUNERAL DIRECTOR ADDRESS <i>W. A. Deermann 6067 Hay Rd</i>						25a. REC'D BY REGISTRAR <i>MAR 9 1967</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>			

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Handwritten signature or text, possibly "Handwritten signature".

Handwritten text at the bottom of the page, including "Handwritten signature" and "Handwritten signature".

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03152 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03143				
1. PLACE OF DEATH a. COUNTY <i>Baltd.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Baltd.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md.</i>			c. LENGTH OF STAY IN lb <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltd. Co. Gen. Hosp.</i>					d. STREET ADDRESS <i>3511 Fox Cliff Ct.</i>			13-1	
3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle <i>BRILLIANT</i> Last					4. DATE OF DEATH Month <i>mar</i> Day <i>18</i> Year <i>1967</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 22 1894</i>		9. AGE (In years lost birthday) yrs. <i>72</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>		11. BIRTHPLACE (State or foreign country) <i>Baltd. Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Abraham C. Levitsky</i>					14. MOTHER'S MAIDEN NAME <i>Clara Elhart</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>218-52-1199T</i>		17. INFORMANT <i>Baltd. Co. Gen. Hosp. Records.</i>			Address <i>Randallstown Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Arteriosclerotic C-V. Disease</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs.</i> <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>none</i> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>D. D. Caples</i> M.D.					22. DATE SIGNED <i>3-18-1967</i>				
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/19/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Herring Run</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltd. Md.</i>		
24. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, Inc. Garmen, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>MAR 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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A.I.

MAR 21 1967

CERTIFICATE OF DEATH

03153

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1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>4 yr 7 mo</u>		d. STREET ADDRESS <u>307 W. Ligonale St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women + Aged Men Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha Brinkley</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hall Brinkley</u>		14. MOTHER'S MAIDEN NAME <u>Lena Guise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-5715</u>	
17. INFORMANT <u>A. Marie Weaver R.N.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (b) <u>Bronchial pneumonia</u> DUE TO (c) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>2 weeks</u> <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8, 1962</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1967</u> , and that death occurred at <u>8:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edmund Day</u>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland Edmund Day M.D.</u>		22d. ADDRESS <u>4-E-33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Will Cook Brooks-Towson</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>1050 York Rd Towson Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03150

STATE OF TEXAS

03150

International Bank Notes
Excluded from
Payment of

Monetary Fund

4-8-55-26

MAR 2 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

SHIPPED TO: WHEELER & THOMPSON FUNERAL HOME, FREDERICKSBURG, VIRGINIA

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
03154		CERTIFICATE OF DEATH	
03145			
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 48 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 107 PATAPSCO AVENUE		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS BALTIMORE, MARYLAND	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EVERETT R. BROOKS		4. DATE OF DEATH Month Day Year MARCH 13 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/14
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BROKENBURG, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SAMUEL BROOKS		14. MOTHER'S MAIDEN NAME ESMA K. TRAYHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 07 62 08	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG ABSCESS, RIGHT, UNDETERMINED ORGANISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA TO BONES, BRAIN, LIVER DUE TO (c) BRONCHOGENIC CARCINOMA, RIGHT			
INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 1/24/67 , 19__, to 3/13/67 , 19__, that (I) (we) last saw the deceased alive on 3/13/67 , 19__, and that death occurred on 3/13/67 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Type) REMOVAL		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY GOOD HOPE CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) SPOTSYLVANIA, VIRGINIA	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE APR 20 1967	
25d. ADDRESS 257 S. CONKLING ST. BALTIMORE, MD.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03155					03146						
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catochville			c. LENGTH OF STAY IN 1b 11yr8mth17dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 2638 Dulaney Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alberta			Middle M.		Last Brown		4. DATE OF DEATH Month 3		Day 5		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1890		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Theodore Laydecker					14. MOTHER'S MAIDEN NAME Carolina Whislen						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 219-01-5593		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage days 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH (year)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NONE							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 11, 1955, to March 5, 1967, that (I) (we) last saw the deceased alive on March 3, 1967, and that death occurred at 6:14 A.M. from the causes and on the date stated above.											
22a. SIGNATURE George A. Rodon M.D.					22b. DATE SIGNED 3-5-67			22c. PHYSICIAN'S NAME (Type) George A. Rodon		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Sater's			23d. LOCATION (City, town or county) Baltimore, Co, Md.			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202					25a. REC'D BY REGISTRAR DATE MAR 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>28</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Tb <u>3 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>202 Winters Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marshall</u> First <u>Brown</u> Middle Last				4. DATE OF DEATH <u>3</u> Month <u>24</u> Day <u>1967</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>11/6/1899</u>		9. AGE (In years lost, birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rollins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dorothy Brown - 202 Winters Lane</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (Aspiration)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Semi Coma</u> DUE TO (c) <u>CVA E Rt. side Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epileptic Seizures due to CVA</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-19-1967</u> , to <u>3-24-1967</u> , that (I) (we) last saw the deceased alive on <u>3-24-1967</u> , and that death occurred at <u>8:20 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Cesar Valle Cervero</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>				22d. ADDRESS <u>8629 Liberty Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law</u>				ADDRESS <u>802 Madison Ave., Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				25b. REGISTRAR'S SIGNATURE			

SALES

02150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03157		Baltimore County				CERTIFICATE OF DEATH		03148	
1. PLACE OF DEATH a. COUNTY Baltimore County Catonsville MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b 1 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CATON RIDGE NURSING HOME					d. STREET ADDRESS 317 Mason Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip Cross (Budzynski)					4. DATE OF DEATH Month 3 - Day 5 - Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1887		9. AGE (In years last birthday) yrs. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Moulder		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Budzynski					14. MOTHER'S MAIDEN NAME Josephine Novakowski				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. Sept 19, 17 215-09-0394		17. INFORMANT Address Edward Miller 4214 Sheldon Ave.				
18. CAUSE OF DEATH (Indicate only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF HEAD OF PANCREAS DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) C GENERALIZED METASTASES DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-10- , 19 66 , to 3-5- , 19 67 , that (I) (we) last saw the deceased alive on 3-5- , 19 67 , and that death occurred at 11 A M , from causes on and on the date stated above.									
22a. SIGNATURE Cesar Valle Caverio					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-5-67		
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO					22d. ADDRESS 8629 Liberty Rd				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.					25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...		

03148

FEDERAL BUREAU OF INVESTIGATION

03148

Maryland

Baltimore

1 Year

317 Second Court

(Continued)

Nov. 6, 1967

Male

Baltimore, Maryland

Housing

Housing

Josephine Kowalski

Henry Kowalski

Yes Page 12, 17 21-02-0301 Edward Miller 1211 Shoben Ave.
 Jan 2, 19

Baltimore, Maryland

Baltimore National

3-8-1967

Postal

MAR 8 1968

1111 & Tolson Bldg. 1907-07 Western Ave.

03158

CERTIFICATE OF DEATH

03149

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN b. <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>627 WASHINGTON AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAULINE C.</u> First Middle Last 4. DATE OF DEATH <u>3</u> <u>24</u> <u>1967</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-23-1882</u> 9. AGE (In years last birthday) <u>84</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CORNELIUS SCHULTE</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOWARD B. STOCKSDALE-ZE-LEXINGTON-ST. MD.</u> Address <u>ZONE-2 BALTO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (b) <u>YEARS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-9, 1954</u> , to <u>3-24, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-24, 1967</u> , and that death occurred at <u>8:30 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Rolando G. Vieta</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO G. VIETA</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD.</u>
24. FUNERAL DIRECTOR <u>Frank A. Seitz</u> ADDRESS <u>814 W 36th St Balto Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03128

03128

MAY 11 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03159

03150

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW JERSEY b. COUNTY CAMDEN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATCO (N.J.)		c. LENGTH OF STAY IN 1b 2 1/2 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 137 JACKSON RD (ATCO N.J.)	
3. NAME OF DECEASED (Type or print) JOHN EDWARD BURCHELL		4. DATE OF DEATH MARCH 31 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-21 (45 yrs)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR - GRAYMUND CORP.		10b. KIND OF BUSINESS OR INDUSTRY PENNA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN BURCHELL		14. MOTHER'S MAIDEN NAME SEVILLA CAMPBELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWII		16. SOCIAL SECURITY NO. 171-14-9564	
17. INFORMANT Dolores Burchell		Address ATCO NJ	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		22. DATE SIGNED 4-1-67	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 4-5-67	23c. NAME OF CEMETERY OR CREMATORY ATCO Cem.	23d. LOCATION (City or Town) ATCO (County) _____ (State) N.J.
24. FUNERAL DIRECTOR Wm. P. Woods		25a. REC'D BY REGISTRAR APR 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

02150

APR 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>03160</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>03151</p> </div> </div>														
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>179 Baltimore Ave</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u></p> <p>d. STREET ADDRESS <u>179 Baltimore Ave.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>									
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>HARRY</u> Middle <u>EDWARD</u> Last <u>BURGESS</u></p>			<p>4. DATE OF DEATH</p> <p>Month <u>March</u> Day <u>21</u> Year <u>1967</u></p>		<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Sept. 7, 1898</u></p>		<p>9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Dept.</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore County</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md</u></p>				<p>12. CITIZEN OF WHAT COUNTRY?</p>				
<p>13. FATHER'S NAME <u>Samuel Burgess</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Sarah Harrison</u></p>								
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>215-22-5986</u></p>		<p>17. INFORMANT Address <u>Mrs. Ruth Burgess, 179 Baltimore Ave.</u></p>								
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u></p> <p>4201 DUE TO (b) <u>Cardio-Vascular Disease</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Emphysema</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u></p> <p><u>5 yrs</u></p>				
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>								<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>						
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1967</u>, to <u>Mar 21, 1967</u>, that (I) <u>last</u> saw the deceased alive on <u>Mar 19, 1967</u>, and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.</p>														
<p>22a. SIGNATURE <u>B B Brumbaugh</u> M.D.</p>								<p>22b. DATE SIGNED <u>3/22/67</u></p>		<p>22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u></p>		<p>22d. ADDRESS <u>5809 Main St Edmonds 27 Md</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			<p>23b. DATE THEREOF <u>3-24-1967</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u></p>			<p>23d. LOCATION (City, town or county) (State) <u>Ellicott City, Md</u></p>						
<p>24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md</u></p>						<p>25a. REC'D BY REGISTRAR <u>MAR 23 1967</u> DATE</p>		<p>25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>						

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FOR STATE
HEALTH DEPT.

03161

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03152

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rosedale c. LENGTH OF STAY IN 1b 40 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 370 Choptank Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rosedale d. STREET ADDRESS 370 Choptank Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE T. (BURKANT) BURKHART		4. DATE OF DEATH Month 3 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1901
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Paul Burkhardt		14. MOTHER'S MAIDEN NAME Josephine Burkhauser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Manue B. Cotter		Address 16 Manchella Ave Coral Gables, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz M.D.		22. DATE SIGNED 3-6-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		23. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-67	
23c. LOCATION (City or Town) (County) (State) Baltimore, Md		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Philip E. Crach ADDRESS 1211 Chesaco Ave.		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03125

03125

MEDICAL EXAMINATION REPORT

1. Name: [illegible]
2. Date: [illegible]
3. Time: [illegible]
4. Location: [illegible]
5. Referring Physician: [illegible]
6. Patient's History: [illegible]
7. Physical Examination: [illegible]
8. Laboratory Tests: [illegible]
9. Results: [illegible]
10. Diagnosis: [illegible]
11. Treatment: [illegible]
12. Prognosis: [illegible]
13. Signature: [illegible]
14. Date: [illegible]

15. Remarks: [illegible]
16. Signature: [illegible]
17. Date: [illegible]
18. Initials: [illegible]
19. [illegible]
20. [illegible]
21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
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97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03162

CERTIFICATE OF DEATH

03153

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 408 South Gilmore Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Everett Middle P. Last Burns		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 22, 1888
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (County & State, or foreign country) U. S. A.
13. FATHER'S NAME Basil R. Burns		14. MOTHER'S MAIDEN NAME Alvina Brandenburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-8318	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Cancer of the Lung 163X IMMEDIATE CAUSE (a) Cancer of the Lung DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Jan. 28, 19 67 to 3/3, 1967 , that (I) (we) last saw the deceased alive on 3/3/67 19 19 , and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-7-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) 3801 Frederick Ave. 21229
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE MAR 6 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

03123

03123

Cancer of the Lung

11+30

1/3/71

MAR 8 1971

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03163

CERTIFICATE OF DEATH

03154

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3315 E. Joppa Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Aquilla F. Burton Sr.				4. DATE OF DEATH Month March Day 5 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 23 1879		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Burton				14. MOTHER'S MAIDEN NAME Mary Kirkendall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-6164		17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4221 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Unat.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-27 , 19 65 , to 3-5 , 19 67 , that (II) (we) last saw the deceased alive on 20 Jan 19 67 , and that death occurred at 6:40 M, from the causes and on the date stated above.							
22a. SIGNATURE John C. Hyle				22b. DATE SIGNED 3-7-67			
22c. PHYSICIAN'S NAME (Type) JOHN C. HYLE MD				22d. ADDRESS 7527 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		23d. LOCATION (City, town or county) (State) Balto Co Md	
24. FUNERAL DIRECTOR C.F. EVANS & SON				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

03160

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2012 E. Jones Rd.

2012 E. Jones Rd.

AMERICA'S F. BURTON CO.

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USA

Manufactured

EXPORT

Mary Kickenball

Benjamin Burton

1924-1925 Family Records

No 1

JOHN O. HYLE MD

2012 E. Jones Rd.

2012 E. Jones Rd.

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2012 E. Jones Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03164

CERTIFICATE OF DEATH

03155

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS Bottom Road	
3. NAME OF DECEASED (Type or print) First Thomas Middle Martin Last Byrne		4. DATE OF DEATH Month March Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-86
9. AGE (In years last birthday) yrs. 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY Lloyd E. Mitchell & Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME FRANK BYRNE	
14. MOTHER'S MAIDEN NAME SALLY KIDD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 216-05-8343	
16. SOCIAL SECURITY NO. 216-05-8343		17. INFORMANT Thomas C. Byrne	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aneurysm DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 20th 19 67 that (I) (we) last saw the deceased alive on March 20th 19 67 , and that death occurred at 11:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Melencio Ventura		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Melencio Ventura M.D.		22d. ADDRESS 7620 York Road, Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-24-1967	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION (City or town) (County) (State) BALTO MD
24. FUNERAL DIRECTOR CHAR. T. EVANS		25a. REC'D BY REGISTRAR MAR 22 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~completely~~ filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03165

03156

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mifflord Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rebecca</u> First <u>Caplan</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 18, 1873</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Sandler</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>257-03-2286A</u>	
17. INFORMANT <u>Mrs Ben Marung</u>		Address <u>419 Upland Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 334X IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accidents</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>47 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1958</u> to <u>MAR 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 8, 1967</u> , and that death occurred at <u>4 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Albert J. Himelefarb</u>		22b. DATE SIGNED <u>3/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert J. Himelefarb</u>		22d. ADDRESS <u>3501 ST. PAUL ST. BALTIMORE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>March 10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bonaventure</u>	23d. LOCATION (City or Town) (County) (State) <u>Savannah Georgia</u>
24. FUNERAL DIRECTOR <u>Sol Lennson & Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
ADDRESS <u>Exc - 6010 Reisterstown Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03152

CONTINUED ON REVERSE

03152

Handwritten notes and bleed-through from the reverse side of the page, including names like "H. J. ...", "J. ...", and "J. ...".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03166						03157					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN b. <u>2 1/2</u> years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 Reisterstown Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>1 Reisterstown Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Marcell Caples</u>						4. DATE OF DEATH Month Day Year <u>March 21 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16, 1907</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Copeland</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>212-36-8977</u>		17. INFORMANT <u>Mr. V. Talbott Caples, 1 Reisterstown Rd. Reisterstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> DUE TO <u>5810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____
21. I certify that (I) (the deceased) attended the deceased from <u>3-3-54</u> , 19 <u>54</u> , to <u>3-21-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-20-67</u> , 19 <u>67</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>D. D. Caples</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>						22d. ADDRESS <u>6 Hanover Rd., Reisterstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			23d. LOCATION (City, town or county) <u>Pikesville, Maryland</u> (State) _____			
24 FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eckhardt</u>						ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08157

CERTIFICATE OF DEATH

03166

Name of Deceased		Date of Death	
John Doe		1915-10-27	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Teacher	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1915-10-28	
Place of Registration		City of New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03167

CERTIFICATE OF DEATH

03158

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 80 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21217	
3. NAME OF DECEASED (Type or print) First GROVER Middle C. Last CAREY		d. STREET ADDRESS 1042 N. STRICKER STREET	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 14. 1922	
9. AGE (In years lost birthday) 45 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CAREY		14. MOTHER'S MAIDEN NAME JULIA SAMUEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 227 14 03 36	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. RIGHT LOBAR PNEUMONIA (c) PULMONARY CONGESTION AND EDEMA		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work _____ of work _____	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/12/66 , 19____, to 3/1/66 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/1/66 , 19____, and that death occurred at 7:15 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-6-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Vernon R. Bailey</i>		25a. REC'D BY REGISTRAR MAR 6 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03154

03154

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03168

CERTIFICATE OF DEATH

03159

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS Rt. 1 - Box 152		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gale Charlene CHAPMAN				4. DATE OF DEATH Month Day Year 3 2 19 67					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-60		9. AGE (In years lost birthday) yrs. 6	IF UNDER 1 YEAR Months Days Hours Min. 19 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Alfred Chapman, Jr.				14. MOTHER'S MAIDEN NAME Effie Irene Turner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Cerebral insufficiency DUE TO (c) Interval Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 1-20 , 19 65 , to 3-2 , 19 67 , that (if) (we) last saw the deceased alive on 3-2 , 19 67 , and that death occurred at 1:30 A.M. from causes and on the date stated above.									
22a. SIGNATURE Richard A. Jones				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3 May 67			
22c. PHYSICIAN'S NAME (Type) Richard A. Jones				22d. ADDRESS Rosewood State Hosp					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-4-67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION (City or Town) (County) (State) DRYANTOWN			
24. FUNERAL DIRECTOR ADDRESS Geo. F. Kelown 1348 N. Galhoun St				25a. REC'D BY REGISTRAR DATE MAY 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

03150

CERTIFICATE OF DEATH

03150

Robert A. Jones
Robert A. Jones
Robert A. Jones

Robert A. Jones
Robert A. Jones
Robert A. Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03169					03160						
1. PLACE OF DEATH a. COUNTY BALTO.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b 42 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater BALTO MED. Center.					d. STREET ADDRESS 4301 PARKTON ST. WOE.						
3. NAME OF DECEASED (Type or print) Holger Christensen					4. DATE OF DEATH Month March Day 14 Year 1967						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/1890		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.N.K.			10b. KIND OF BUSINESS OR INDUSTRY U.N.K.			11. BIRTHPLACE (County & State, or foreign country) LINCOLN Ne.B.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME C M CHRISTENSEN					14. MOTHER'S MAIDEN NAME UNK						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 1918-1919		17. INFORMANT 336-074992		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. Seizure and Resp. arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Renal Failure and Pneumonia DUE TO (c) Metastatic Neck Carcinoma - 1° site PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN										INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that it (this hospital) attended the deceased from Jan. 16 , 1967, to March 14 , 1967, that it (we) last saw the deceased alive on March 13 , 1967, and that death occurred at 4:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Miguel R. Alonso					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 14, 1967				
22c. PHYSICIAN'S NAME (Type) Dr. Miguel R. Alonso					22d. ADDRESS Greater Balto. Medical Center						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Hubbard Funeral Home					ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR 21 MAR 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

03160

03160

BALTO

MARYLAND

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GASTON BALTO MED. Center. 4201 PARKWAY ST.

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C M CHRISTIANSON

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LINCOLN HOSP. U.S.A.

United States National Co. 1000 1000 1000

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03170

03161

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWSON - 4		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH'S HOSPITAL		d. STREET ADDRESS 428 Folcroft 21224	
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS CLEAVER, Jr.		4. DATE OF DEATH Month Day Year 3 20 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1942
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Cleaver Sr.		14. MOTHER'S MAIDEN NAME Ethel Wiegand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-42-7884	
17. INFORMANT Lewis Cleaver Sr., Father, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive internal bleeding DUE TO (b) Laceration of spleen and lungs DUE TO (c) Fatty alteration of liver			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty alteration of liver			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver involved in three car accident	
20c. TIME OF INJURY Month, Day, Year Hour Min. 4:50 p.m. 3-20 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beltway		20f. (City or town) (County) (State) Baltimore Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 3-21-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/24/67	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

03161

03170

June 14, 1945

Baltimore, Md.

Arnold W. and

750-1-7811 Lewis Weaver Co., Baltimore, Md.

Enclosed for you are two

copies of the report

on the subject of the

Baltimore, Md.

MAR 1 1946

7/24/45

to Bureau of
2000 Bureau Lane

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03177

CERTIFICATE OF DEATH

03162

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 33 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 56 Broadship Road				e. STREET ADDRESS 56 Broadship Road			
3. NAME OF DECEASED (Type or print) First John Middle J. Last Coburn				4. DATE OF DEATH Month March Day 16 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/84	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 13-1 Days 13-1		IF UNDER 24 HRS. Hours 13-1 Min. 13-1		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Gen. Foreman				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas Coburn				14. MOTHER'S MAIDEN NAME Ellen Finnerty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-07-6938-A		17. INFORMANT (Son) William L. Coburn, 56 Broadship Rd. Dundalk,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Accident - 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility. DUE TO (c) A-S-C-V Disease				INTERVAL BETWEEN ONSET AND DEATH 4 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Baltimore, Maryland							
21. I certify that (I) (this hospital) attended the deceased from 3/16/67 to 3/16/67 , that (I) (we) last saw the deceased alive on 3/16/67 , 19 19 , and that death occurred at 8:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE M. B. Davis				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis				22d. ADDRESS M. D. 6800 Mornington Rd. Dundalk, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR MAR 20 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

53180

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03172

CERTIFICATE OF DEATH

03163

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>125 CITY VIEW AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>GENEVIEVE</u> Middle <u>COLEMAN</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6/16/08</u>		9. AGE (In years last birthday) <u>58</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASSISTANT HOSPITAL LAUNDRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WESTMINSTER, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CLARENCE STAUP</u>	
14. MOTHER'S MAIDEN NAME <u>GERTRUDE ETZLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>216-10-7317</u>		17. INFORMANT <u>PATIENT CHART</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> , 19 <u>67</u> , to <u>3-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-9</u> , 19 <u>67</u> , and that death occurred at <u>10:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Mario B. Ines</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARIO B. INES M.D.</u>		22d. ADDRESS <u>GBMC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEM. GARDENS</u>		23d. LOCATION (City or Town) (County) (State) <u>FINKSBURG MARYLAND</u>	
24. FUNERAL DIRECTOR <u>J. E. Innes Jr.</u> ADDRESS <u>Westminster - Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03162

03172

MARKING CARDS

BALTIMORE

8 DAY

BALTIMORE

COAST

GREATER BALTIMORE

SCOTTY VIEW

CLARA

GENEVA COLEMAN

FEMALE CAR

6/10/08 28

ALCOHOLIC CHART

EXHIBIT MEMORANDUM

1987

03173

CERTIFICATE OF DEATH

03164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21204</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			d. STREET ADDRESS <u>1400 Jeffers Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Henry John Correlli</u>			4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-17</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing (own)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chester, Penn.</u>	
13. FATHER'S NAME <u>Enrico Correlli</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>UNKN.</u>		17. INFORMANT <u>Patient's Chart</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1967</u> to <u>March 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1967</u> , and that death occurred at <u>4:20 P.M.</u> from causes on and the date stated above.					
22a. SIGNATURE <u>J. Mellyza</u>			22b. DATE SIGNED <u>3/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>KEITH A. MANLEY GMC. Charles, Md</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

03173

03173

Mark Hypocrite Apaches

June 19 1961

June 19 1961

KEITH A. MANLEY CMO, Chief, TB

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03174

CERTIFICATE OF DEATH

03165

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 54 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 33 LOCUST DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JAMES LEO COYLE		First Middle Last		4. DATE OF DEATH Month MARCH Day 6 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 7, 1903		9. AGE (In years lost birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR			10b. KIND OF BUSINESS OR INDUSTRY STATE OF MD.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN COYLE				14. MOTHER'S MAIDEN NAME MARY MULLEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212 03 93 85		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 11201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA (c) ARTERIOSCLEROTIC HEART DISEASE WITH MURAL THROMBOSIS (e) PULMONARY AND SPLENIC INFARCTS						INTERVAL BETWEEN DEATH AND DEATH RECENT RECENT UNKNOWN RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN. 11 , 19 67 , to MARCH 6 , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 6 , 19 67 , and that death occurred at 115A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-9-67		23c. NAME OF CEMETERY OR CREMATORY NEW CATHARAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR FARLEY CAVANAUGH				ADDRESS FUNERAL HOME 6601 PRED. AVE 21228 BALTIMORE		25a. REC'D BY REGISTRAR MAR 9 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03108

03108

BALTIMORE

BALTIMORE

BALTIMORE

BALTIMORE

21 DATE

POST HOWARD

23 10000 10000

LABORERS AND DISTRICT HOSPITAL

67

6

WINTER

COFFEE

100

JAMES

FEBRUARY 1, 1903

WINTER

U.S.A.

BALTIMORE, MARYLAND

STATE OF MD.

INSPECTOR

NAME MISSING

JOHN COLE

VA HOSPITAL

212 03 23 02 CLINICAL RECORDS POST HOWARD, MARYLAND

WINTER

FOLLOWING RECORD

WINTER

WINTER

WINTER

LABORERS AND DISTRICT HOSPITAL

WINTER

LABORERS AND DISTRICT HOSPITAL

67

MARCH 6

JAN. 11

67

MARCH 6

36000

VA POST HOWARD, MARYLAND

POST V. JAMES, M.D.

BALTIMORE, MARYLAND

NEW CATHEDRAL CENTRAL

WINTER CATHEDRAL

WINTER

WINTER CATHEDRAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2a should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G387 11/3/67 pc

03175

CERTIFICATE OF DEATH

03166

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>4207 1/2 Raspe Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last <u>Cymek</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-92</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-739A</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Congestive Heart Failure</u> (b) <u>Right Upper Lobe Pneumonia</u> DUE TO <u>Right Upper Lobe Pneumonia</u> (c) <u>Right Upper Lobe Pneumonia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1967</u> to <u>March 15, 1967</u> , that (I) (we) lost saw the deceased alive on <u>March 15, 1967</u> , and that death occurred at <u>4:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Mr. A. Gongon</u>		22b. DATE SIGNED <u>March 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>		22d. ADDRESS <u>GR. MC - Charles St - 112</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>
24. FUNERAL DIRECTOR <u>John C. Miller Inc. - 6415 Belair Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03155

OFFICE OF THE

03155

Right Upper Side of the
Carpenter's Head Tailor
Acute Pulmonary Tuberculosis

MANUEL A. GONCALVES

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, or any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03176

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03167

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA-St. Joseph's Hospital		d. STREET ADDRESS 8742 Lackawanna Ave.	
3. NAME OF DECEASED (Type or print) Mary R. Davenport		4. DATE OF DEATH Month March Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 47 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence J. Franz		14. MOTHER'S MAIDEN NAME Margaret Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-2902	
17. INFORMANT Mr. William H. Davenport		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion Sudden DUE TO (b) Chronic Alcoholism DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5+ yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/67.	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

22. DATE SIGNED
3/9/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03177		CERTIFICATE OF DEATH		03168	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2917 Dummurry Road		d. STREET ADDRESS 2917 Dummurry Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First Middle Last W. DAVIS		4. DATE OF DEATH Month Day Year March 23, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1906	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min. 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Ernest R. Davis		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Barbara Davis, 2917 Dummurry Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Benignlygenic Ca to Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1621 DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) emphysema, obstructed; congested Heart failure					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 19 63 to 3/22, 19 67 , that (I) (we) last saw the deceased alive on 3/22, 19 67 and that death occurred at 3:22 A.M. from causes and on the date stated above.					
22a. SIGNATURE Paul G. Koukoulas		22b. DATE SIGNED 3/23/67			
22c. PHYSICIAN'S NAME (Type) Paul G. Koukoulas		22d. ADDRESS 6511 O'Donnell St.,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Parkville, Md.	
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

03182

OFFICE OF THE

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Director

Assistant

Chief

Chief

Chief

Chief

Chief

Chief

Chief

For 12, 1960

For 12, 1960

Chief

Chief

For 12, 1960

For 12, 1960

For 12, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03178

CERTIFICATE OF DEATH

03169

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 Mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 18 Nunnery Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amy France Day		4. DATE OF DEATH Month March Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1880
9. AGE (In years last birthday) yrs. 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John France		14. MOTHER'S MAIDEN NAME Augusta Ernst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-54-8221	
17. INFORMANT Robert G. Parrott		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the left Breast DUE TO (b) with metastases to Bone DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1963	20f. (City or town) (County) (State) 3/29/67
21. I certify that (I) (this hospital), attended the deceased from 1963 to 3/29/67 , that (I) was last saw the deceased alive on 3/29/67 , and that death occurred 12:30 PM , from causes on the date stated above.			
22a. SIGNATURE W.E. McGrath		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) Dr. W.E. McGrath		22d. ADDRESS 1303 Frederick Ave. Catonsville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-1-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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MINISTRE DE LA SANTE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

03179		03170	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home		d. STREET ADDRESS 8931 Liberty Rd.	
3. NAME OF DECEASED (Type or print) Stanley Chester Day		4. DATE OF DEATH Month Mar. Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1887
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner Bus Service Trans.		10b. KIND OF BUSINESS OR INDUSTRY Trans.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Day		14. MOTHER'S MAIDEN NAME Martha Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-9810A	
17. INFORMANT Stanley C. Day Jr.		Address Randallstown 8931 Liberty Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon c 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) metastasis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			INTERVAL BETWEEN ONSET AND DEATH 7 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/25 , 19 60 , to 3/4 , 19 67 , that (I) (we) last saw the deceased alive on 2/25 , 19 67 , and that death occurred at 3/4 , 19 67 , from causes and on the date stated above			
22a. SIGNATURE Dr. Morton Ellin		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 8629 Liberty Rd. Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/6/67	23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial	23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.
24. FUNERAL DIRECTOR Loring Byers		25a. REC'D BY REGISTRAR MAR 6 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S ADDRESS 8728 Liberty Rd. Randallstown, Md.	

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NAME		DATE		TIME	
LAST		FIRST		MIDDLE	
SUFFIX		AGE		SEX	
RACE		RELIGION		EDUCATION	
MARRIED		DIVORCED		WIDOWED	
SINGLE		SEPARATED		OTHER	
MILITARY SERVICE		CIVIL SERVICE		BUSINESS	
PROFESSION		INDUSTRY		OCCUPATION	
EMPLOYER		EMPLOYMENT		SALARY	
RESIDENCE		CITY		STATE	
COUNTRY		ZIP		PHONE	
FAMILY		CHILDREN		PARENTS	
SIBLINGS		AUNT		UNCLE	
GRANDPARENTS		OTHER		REMARKS	

03180

CERTIFICATE OF DEATH

03172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON - 4		c. LENGTH OF STAY IN 1b 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS WILLIAM DEVOY		4. DATE OF DEATH Month Day Year March 16th 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11th 1908
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Rite Way Driving	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John DeVoy		14. MOTHER'S MAIDEN NAME Mary (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-1211	
17. INFORMANT Mrs. Dorothy C. DeVoy (Widow)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1966 , to March 16, 1967 , that (I) (we) saw the deceased alive on 3/16/67 and that death occurred at 10P. M, from causes and on the date stated above.			
22a. SIGNATURE Charles E. Carr		22b. DATE SIGNED 3/19/67	
22c. PHYSICIAN'S NAME (Type) Charles E. Carr M.D.		22d. ADDRESS 3900 N. Charles Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/20/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Balto
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25a. REC'D BY REGISTRAR 21212	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 27 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03181

03173

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE HIGHLANDS</u> c. LENGTH OF STAY IN 1b <u>6 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4106-OLD ANNAPOLIS ROAD (21227)</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE HIGHLANDS-21227</u> d. STREET ADDRESS <u>4106-OLD ANNAPOLIS RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>MARY E. DEW</u> First Middle Last				4. DATE OF DEATH <u>MARCH 3 1967</u> Month Day Year															
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 7, 1872</u> 94 yrs.		9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHARLES T. TURNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY R. ALLISON</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MRS. EDNA E. FONT 2 (DHT.)</u> Address <u>1221-PO TAPSCOTT ST. BALTO MD 21230</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>athero-sclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>senility</u> (c)												INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>3-3</u> 1967 , that (I) (we) last saw the deceased alive on <u>3-3</u> 1967 , and that death occurred at <u>11:40 PM</u> on the causes and on the date stated above.																			
22a. SIGNATURE <u>J. Duer Moories</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3-6-67</u>									
22c. PHYSICIAN'S NAME (Type) <u>J. DUER MOORIES</u>						22d. ADDRESS <u>3105 BELAIR RD.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>MARCH 7, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>				23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Curtis E. Evans</u>						ADDRESS <u>1400 S. BALTO</u>				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03121

03121

CERTIFICATE OF DEATH

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03182

CERTIFICATE OF DEATH

03174

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21206 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 8605 Dilegge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dominic Dilegge, Sr.		4. DATE OF DEATH Month March Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1875
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Balto. City Employee		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Dilegge		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-1508	
17. INFORMANT Mrs. Mary Dilegge		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease DUE TO (c) Terminal pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/5/ , 1967, to 3/11/ , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/11/ 1967, and that death occurred at 11:25 M, from causes and on the date stated above.			
22a. SIGNATURE Jaime Singzon		22b. DATE SIGNED March 11, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/67.	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03185

4180

1909-1910

Journal of Management Education 26(7)

7. 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03183

CERTIFICATE OF DEATH

03175

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21224</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>23 North Ellwood Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Rebecca Dippel (Dippel)</u>		4. DATE OF DEATH Month Day Year <u>Mar. 11 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Baltimore U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ohliver Wentworth</u>		14. MOTHER'S MAIDEN NAME <u>Kate Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-54-3092</u>	
17. INFORMANT <u>Mrs Catherine Liebau</u>		Address <u>Spring Grove Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4683</u> DUE TO (b) <u>Heart block</u> DUE TO (c) <u>Elephantiasis in both leg.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-6</u> , 19 <u>66</u> to <u>3-11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-11</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Evelio A. Felipe</u> M.D.		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EVELIO A FELIPE</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Maryland</u>	
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>frank judge</u>			

5160

62150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03184

03176

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 3241 MAGNOLIA AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last CARL HAROLD DIXON		4. DATE OF DEATH Month Day Year MARCH 26 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 6, 1897
9. AGE (In years last birthday) yrs. 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK	
11. BIRTHPLACE (County & State, or foreign country) WEST HILL, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DIXON		14. MOTHER'S MAIDEN NAME MAMIE JENKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 333 14 96 38	
17. INFORMANT VA HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF TONGUE & FLOOR OF MOUTH DUE TO (b) BRONCHOPNEUMONIA, BILATERAL DUE TO (c) PULMONARY EDEMA, MARKED, BILATERAL	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 6 , 19 67 , to MARCH 26 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 26 , 19 67 , and that death occurred at 830P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/29/67	
23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) DOGWOOD ROAD, BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>Wm. J. Tickner & Sons</i>		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. NORTH & PENNSYLVANIA AVE. BALTIMORE, MD.	

03150

4860

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03185

CERTIFICATE OF DEATH

03177

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>				d. STREET ADDRESS <u>2430 Etting St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Phillip Alexander Dixon</u>				4. DATE OF DEATH Month Day Year <u>March 21 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-44</u>		
9. AGE (In years lost birthday) <u>22 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Obadiah Thompson</u>				
14. MOTHER'S MAIDEN NAME <u>Ollie Lee Dixon</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Medical Records, Rosewood State Hosp.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4330</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatiz heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (H) (this hospital) attended the deceased from <u>3-34</u> , 196 <u>0</u> , to <u>3-21</u> , 196 <u>7</u> , that (H) (we) last saw the deceased alive on <u>3/21 1967</u> , and that death occurred at <u>3:32 P.M.</u> from causes and on the date stated above.								
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/21/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Zsolt Koppanyi, M.D.</u>				22d. ADDRESS <u>Rosewood State Hosp., Owings Mills, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO.</u>		
24. FUNERAL DIRECTOR <u>Geo. J. Kelan 1348 Calhoun St</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03133

CHRONICLE OF DEATH

03133

03133

03133

03133

03133

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 (M)

03186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03178

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 42 Chandell Road		d. STREET ADDRESS 42 Chandell Road	
3. NAME OF DECEASED (Type or print) RALPH DODD		4. DATE OF DEATH (Pronounced) March 30, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/22
9. AGE (In years lost birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airplane Mechanic	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wesley Dodd		14. MOTHER'S MAIDEN NAME Lily Justice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Alma L. Dodd 42 Chandell Rd. Essex, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon Monoxide DUE TO (c) Conflagration		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mattress caught fire	
20c. TIME OF INJURY Month Day Year Hour a.m. 3-29 or p.m. 3-30 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Essex BALTIMORE MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		22. DATE SIGNED March 31, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Weaverville, North Carolina	
24. FUNERAL DIRECTOR James M. Fields - Balto., Md.		25a. REC'D BY REGISTRAR DATE APR 4 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Justice	

03130

03130

U. S. A.

North Carolina

North Carolina

High Justice

High Justice

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High Justice

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03187

CERTIFICATE OF DEATH

03179

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8051 Philadelphia Road		d. STREET ADDRESS 8051 Philadelphia Road	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle DOERING Last DOERING		4. DATE OF DEATH March 3 19 67 Month Ooy Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/93
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Packer		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Hoffman		14. MOTHER'S MAIDEN NAME Minnie Borgmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 215-22-0563		16. SOCIAL SECURITY NO. 215-22-0563	
17. INFORMANT Margaret Ciampa, dght, 8051 Phila. Rd.		Address 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure - Coma 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Pancreas. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October , 19 67 , to Mar 3 , 19 67 , that (I) (we) last saw the deceased alive on 3- 19 67 , and that death occurred at 8:22 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. John B. Littleton		22b. DATE SIGNED 3-3-67	
22c. PHYSICIAN'S NAME (Type) Dr. John B. Littleton		22d. ADDRESS 1012 Old North Point Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/6/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR MAR 6 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03178

03181

CERTIFICATE OF DEATH

Ballistics

Residence

U.S. Army

92nd Airborne Division

DO 100

11th Airborne

1st Airborne

73

01/1/93

Remains White

Interred at Jackson, Mississippi, No.

Interred at Jackson, Mississippi

1/2/93

1/2/93

11-1-93

11-1-93

11-1-93

11-1-93

11-1-93

11-1-93

10-1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03188		03180	
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sparks. 03-1</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>Cold Bottom Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MASON</u> Middle <u>Ted</u> Last <u>DOLLY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 26, 1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 2 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Engines</u>	
11. BIRTHPLACE (State or foreign country) <u>Key, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar S. Dolly</u>		14. MOTHER'S MAIDEN NAME <u>Lennie Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-7034</u>	
17. INFORMANT <u>Mrs. Josephine Meads</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A.M. France</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A.M. FRANCE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>3/12/67</u>		Address (Street, city, town, or county) <u>PARKTON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dolly Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Old Fields, W. Va.</u>
24. FUNERAL DIRECTOR <u>J. Jacob Kortenstien</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
ADDRESS <u>New Freedom, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

08120

6210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03189					03181						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		BALTIMORE			a. STATE		MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		BALTIMORE			b. COUNTY		BALTIMORE				
c. LENGTH OF STAY IN 1b		LIFE			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS						
GREATER BALTIMORE MEDICAL CENTER					517 PATUXENT AVE.						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
BABY BOY			DANNENFELSER		MARCH		20		1967		
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		NEVER MARRIED <input checked="" type="checkbox"/>		3/20/67		yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
CHILD				BALTIMORE, MARYLAND		U.S.A.					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
JOSEPH DANNENFELSER					SHARON ANNE WHEELER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
					JOSEPH DANNENFELSER			517 PATUXENT AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
7625 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
IMMATURITY (700 GMS.)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (this hospital) attended the deceased from 3/20, 1967, to 3/20, 1967, that (we) last saw the deceased alive on 3/20/67 1967, and that death occurred at 1:10 PM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
Margaret E. Lang MD										3/20/67	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
MARGARET E. LANG MD					GREATER BALTIMORE MEDICAL CENTER						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
BURIAL		MAR 22 1967		HOLY REDEEMER CEMETERY		4430 BELAIR ROAD		MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DIPPEL BROS INC 1800 E LOMBARD ST						MAR 23 1967		J Charles Judge			

03150

03150

IMMATURE (100 GMS.)
MUSCULAT ATROPHIC



X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03190		CERTIFICATE OF DEATH				03182			
1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>3 y. 5. 8 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL 21128</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>9937 Richlyn xxxxxx DR.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>n.m.y.</u> Last <u>DRUMMOND</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>19 67</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/20/92</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOSTESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CZECHOSLOVAKIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOSEPH A. VESELY</u>					14. MOTHER'S MAIDEN NAME <u>MARY Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>LOUIS F. VESELY</u> Address <u>Richlyn 9937 xxxxxx DR.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>1</u> (b) <u>1</u> DUE TO <u>1</u> (c) <u>1</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>63</u> , to <u>3-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10</u> 19 <u>67</u> , and that death occurred at <u>6 p.m.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>Morris Meiller</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>MARCH 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS MEILLER</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02150

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03191

CERTIFICATE OF DEATH

03183

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>12 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>6992 Apt. 1C Millbrook</u>			
3. NAME OF DECEASED (Type or print) First <u>ISADORE</u> Middle <u>(NMI)</u> Last <u>DUBANSKY</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>4/25/94</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>BEARNARD DUBANSKY</u>			
14. MOTHER'S MAIDEN NAME <u>LENA BECKER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>800-00-5648</u>				17. INFORMANT Address <u>Park Dr. Apt.</u> <u>Mrs. Ray Dubansky, 6992 Millbrook - 1-C</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/24/67</u> , 19 <u>67</u> , to <u>3/27/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/27/67</u> , 19 <u>67</u> , and that death occurred at <u>9:20 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Dr. Samuel Tompakou</u>				22b. DATE SIGNED <u>3/27/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. SAMUEL TOMPAKOU</u>				22d. ADDRESS <u>Baltimore County General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ohr Knesseth Israel Sford</u>			
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>					
25a. REC'D BY REGISTRAR <u>31 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03183

CERTIFICATE OF DEATH

03183

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS

THE REGISTRAR OF DEATHS

THE REGISTRAR OF DEATHS

THE REGISTRAR OF DEATHS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03192

CERTIFICATE OF DEATH

03184

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Baltimore		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9112 Orbitan Road		d. STREET ADDRESS 9112 Orbitan Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE Middle FRANCES Last DUNKEL		4. DATE OF DEATH Month March Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1896
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months 70 Days 70	11. IF UNDER 24 HRS. Hours 70 Min. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel French	
14. MOTHER'S MAIDEN NAME Anna E. Gilbert		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-12-9187		17. INFORMANT Mrs. Frances Petza Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DUE TO RENAL DISEASE (c) YEARS			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1939 to 3-10 , 1967, that (I) (we) saw the deceased alive on 3/10 , 1967, and that death occurred at 5P M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J Thomas MD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/14/67
22c. PHYSICIAN'S NAME (Type) ANTHONY J THOMAS MD		22d. ADDRESS 4600 YORK ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 14 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

42150

SE150

41525 . 31 . 031mm . 201mm . 200 . 1 . 00000

CERTIFICATE OF DEATH

Reg. Dist. No.

03185

03193

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md 21222 b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 11 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2021 DUNDALK AVE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 13.1	
3. NAME OF DECEASED (Type or print) First Middle Last MARY KELLEY DURACZYK		4. DATE OF DEATH Month Day Year 3 / 25 / 1967 19	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1917
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-OPERATOR		12. KIND OF BUSINESS OR INDUSTRY RETL. GROCERY	
13. BIRTHPLACE (State or foreign country) WEST VIRGINIA		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME ANDREW KELLEY		16. MOTHER'S MARRIED NAME ELMER J. DURACZYK - # 2	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 234/10/0846	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apnea 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Convulsions DUE TO (c) G L Bleeding		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 2 , 19 67 , to MARCH 25 , 19 67 , that I last saw the deceased alive on MARCH 25 , 19 67 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTIMORE, Md DATE SIGNED 3/25/67			
ACTUAL SIGNATURE George J. Dendrino		M.D. E. F. Reed	
PHYSICIAN'S NAME (Type) GEORGE J. DENDRINO			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/29/67	22c. NAME OF CEMETERY OR CREMATORY GRONS. FAITH	22d. LOCATION (City, town, or county) (State) BALTO. Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE W. Arthur Bradley		24a. REC'D BY REGISTRAR MAR 28 1967	
ADDRESS W. Arthur Bradley		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03185

03185

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
DATE OF DEATH <i>March 15, 1918</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		
DISEASE OR INJURY <i>Myocardial Infarction</i>		PREVIOUS ILLNESS <i>None</i>		
SIGNS AND SYMPTOMS <i>None</i>		TREATMENT <i>None</i>		
DATE OF BIRTH <i>March 15, 1873</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	EDUCATION <i>High School</i>	
OCCUPATION <i>None</i>		MARRIAGE <i>None</i>		
RELIGION <i>None</i>		POLITICAL PARTY <i>None</i>		
SIGNED BY <i>John A. Smith</i>		WITNESSES <i>None</i>		
DATE <i>March 15, 1918</i>		PLACE <i>Home</i>		

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23b Film #G386 3/0/67 pc

03194

CERTIFICATE OF DEATH

03186

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u> 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>509 Old Home Road</u>		d. STREET ADDRESS <u>509 Old Home Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B.</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1881</u>
9. AGE (In years last birthday) yrs. <u>86</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Pipe Coverer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Duvall</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216099043</u>	
17. INFORMANT <u>Joseph Duvall</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of the Heart Disease</u> DUE TO (b) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>3-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-10</u> , 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wyman K. Wong</u>		22b. ADDRESS <u>3209 North Point Road</u> <u>Baltimore, Md. 21222</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wyman K. Wong</u>		22d. ADDRESS <u>Charlesmont Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

03186

03186

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03186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03195

CERTIFICATE OF DEATH

03187

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>6 days</u>		30-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>		d. STREET ADDRESS <u>2227 Fleet St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> XXXXXX <u>Eberle</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>Can</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-7-1883</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL Florist</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX JOHN EBERLE</u>		14. MOTHER'S MAIDEN NAME <u>LENA SCHWARTZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>215-32-7887-A-6121</u>	
17. INFORMANT <u>Mr. RAY EBERLE (Son)</u>		Address <u>Margienn Ave. Baltimore 21206</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Middle Cerebral</u> 332X DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1967</u> to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>5:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Suzelina M. Oteyza</u>		22b. DATE SIGNED <u>March 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUDILINA M. OTEYZA</u>		22d. ADDRESS <u>GBMC-6701 N. CHARLES Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FIRST EVANGELICAL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

03183

ORDINANCE OF 1901

03183

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words are difficult to discern but appear to include:]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03196

CERTIFICATE OF DEATH

03188

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN lb 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		d. STREET ADDRESS 2 TERRACE ROAD	
3. NAME OF DECEASED (Type or print) BURNICE SUSAN ECCARD		4. DATE OF DEATH 3/14/67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME DAVID RIDENOR		14. MOTHER'S MAIDEN NAME LIDDIE REESE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. 220-28-928	
17. INFORMANT PATIENT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE & ARTERIOSCLEROTIC DUE TO CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHIAL ASTHMA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/7 , 19 67 , to 3/14 , 19 67 , that (I) (we) last saw the deceased alive on 3/14 , 19 67 , and that death occurred on 3/14 AM, from causes and on the date stated above.			
22a. SIGNATURE John E. Adams		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) JOHN E. ADAMS		22d. ADDRESS GREATER BALTO. MED. CENTER	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-17-67	23c. NAME OF CEMETERY OR CREMATORY Bever Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Beaver Creek, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr.		25a. REC'D BY REGISTRAR MAR 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03197

CERTIFICATE OF DEATH

03189

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saratoga Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>St. Clement's Infirmary</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Einhaus</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1897</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roman Cath. Priest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.S.S.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Einhaus</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hilten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Rev. Henry V. Sattler</u>		Address <u>1225 E. Eager St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>66</u> , to <u>3/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> , 19 <u>66</u> , and that death occurred at <u>9:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Henry J. Houska</u>		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY J. HOUSKA M.D.</u>		22d. ADDRESS <u>333 S. EAST AVE BALTO MD 21224</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03182

03182

EXHIBIT OF DEATH

1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03198					03190				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Md.</u> b. COUNTY <u> </u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1-Day</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Home</u>					d. STREET ADDRESS <u>4709 Sayer Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elsie J. H. Elenbrok</u>			First Middle Last		4. DATE OF DEATH <u>March 24, 19 67</u>		Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1885</u>		9. AGE (in years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Krumpholz</u>					14. MOTHER'S MAIDEN NAME <u>? </u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>21-43-4471</u>		17. INFORMANT <u>Amelia J. Wehrle</u>		Address <u>4709 Sayer Ave. Balto. Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 DUE TO (b) <u>Arteriosclerotic C. V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Smoking</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1967</u> to <u>March 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 23, 1967</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>D. C. MacLaughlin</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/24/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>					22d. ADDRESS <u>303 N. Rolling Road</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (city, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>					ADDRESS <u>3512 Frederick Ave, Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

03130

03130



03130

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03199

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03191

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b Reisterstown		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eline Funeral Home		d. STREET ADDRESS Dover Road	
3. NAME OF DECEASED (Type or print) DOROTHY ANN ELLIOTT		4. DATE OF DEATH Month 3 Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Secretary at C.R.I.		9. AGE (In years lost birthday) yrs. 55	11. BIRTHPLACE (State or foreign country) Indiana
10b. KIND OF BUSINESS OR INDUSTRY Medical Secretary at C.R.I.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter E. Kirby		14. MOTHER'S MAIDEN NAME Lula Crooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Morris A. Elliott		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was involved in collision of 2 cars and gas truck 20c. TIME OF INJURY Month, Day, Year 12:45 p.m. 3 -6 19 67 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) (County) (State) Westminister Carroll Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 3-6-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/7/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons		25. REG'D BY REGISTRAR Mar 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

03181

03180

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03200

CERTIFICATE OF DEATH

03192

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21214</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Manor</u>				d. STREET ADDRESS <u>6405 Hartford Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Endres</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 17, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irvin Alsruhe</u>				14. MOTHER'S MAIDEN NAME <u>Olga ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-52-6716</u>		17. INFORMANT <u>Endres</u> <u>Carl J. Endres, Sr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>4221</u> DUE TO (b) <u>Arteriosclerotic C-V disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Terminal uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis 1952</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 24, 1956</u> to <u>March 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1967</u> , and that death occurred at <u>4:10 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>H.V. Harbold</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u>				22d. ADDRESS <u>4706 Harford Rd Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03201					CERTIFICATE OF DEATH					03193				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. LENGTH OF STAY IN 1b 1 yr 2 mon +					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, 21212 Rogers Forge				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney Towson Nursing Home					d. STREET ADDRESS 255 Rogers Forge Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Elizabeth Middle F. Last Englar					4. DATE OF DEATH Month March Day 14 Year 19 67									
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 21, 1885		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 03-1		IF UNDER 24 HRS. Hours 03-1 Min. 03-1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Carroll County, Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Charles Franklin					14. MOTHER'S MAIDEN NAME Sarah Elizabeth Shipley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Address Baltimore 04 Dulaney Towson Nursing Home, 111 West Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serum										INTERVAL BETWEEN ONSET AND DEATH 4 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from Jan 1964 to Mar 14, 1967 , that (I) (we) last saw the deceased alive on Mar 14 19 67 , and that death occurred at 9:30 M, from the causes and on the date stated above.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE M. Paul Byerly					22b. DATE SIGNED 3/15/67					22c. PHYSICIAN'S NAME (Type) M. Paul Byerly				
22d. ADDRESS 5820 York Rd Balto 12 Md					23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3/16/1967				
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery					23d. LOCATION (City, town or county) (State) Pikesville, Md.					24. FUNERAL DIRECTOR Wm. J. Tinkner & Sons				
24a. REC'D BY REGISTRAR Charles Jones					24b. REGISTRAR'S SIGNATURE Charles Jones					24c. DATE MAR 17 1967				

03103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03202

CERTIFICATE OF DEATH

03194

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		d. STREET ADDRESS <u>825 E. Lake Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA</u> <u>ELLA</u> <u>ENSOR</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>4</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1889</u> <u>78</u> yrs.
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Smoot</u>		14. MOTHER'S MAIDEN NAME <u>Clara R. Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Ira Ensor</u>		Address <u>same address as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis, abdomen</u> DUE TO (b) <u>Acute renal insufficiency</u> DUE TO (c) <u>Arteriosclerosis cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-4</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-4</u> 1967, and that death occurred at <u>12:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Marchena</u>		22b. DATE SIGNED <u>3-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>OCTAVIO DE MARCHENA</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Zimmerman & Son</u>		25. REC'D BY REGISTRAR DATE <u>MAR 7 1967</u>	
ADDRESS <u>Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DECEMBER

DECEMBER 10, 1941

03550

7

TO MEMORANDUM

TO: Mr. [illegible]

FROM: Mr. [illegible]

10-4-2

12-4-1

1-2

10-4-2

10-4-2

10-4-2

10-4-2

10-4-2

10-4-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03203					CERTIFICATE OF DEATH					03195				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Inverness					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 03-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1731 Inverness Ave.					d. STREET ADDRESS 1766 Brookview Rd # 22					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MARY JANE ERHARDT					4. DATE OF DEATH Month Day Year March 31, 1967.									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1915		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work					10b. KIND OF BUSINESS OR INDUSTRY At Home					11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Elmer McDonald					14. MOTHER'S MAIDEN NAME Mary Donohue				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 215-07-9218					17. INFORMANT George W. Erhardt Same.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 1561 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 29 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from Nov 30, 1967 to Nov 31, 1967 , that (I) (we) last saw the deceased alive on Nov 30, 1967 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Stephen C. Mackowiak M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Stephen C. Mackowiak					22d. ADDRESS 6714 Holabird Ave., Balto., 24, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-67.		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) 7401 German Hill Rd., Ba. Co., Md.								
24 FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler ADDRESS 901 S. Conkling St. Balto., 21224, Md.					25a. REC'D BY REGISTRAR APR 4 1967 DATE					25b. REGISTRAR'S SIGNATURE Charles Judge				

CASEC

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #15 Film #0386 3/14/67 pc									
03204					03196				
1. PLACE OF DEATH a. COUNTY Baltimore County Catonsville MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home					d. STREET ADDRESS 5625 Lothian Rd.				
3. NAME OF DECEASED (Type or print) Raffaele or Ralph Esposito					4. DATE OF DEATH March 8 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1st-1890		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Retired		10b. KIND OF BUSINESS OR INDUSTRY Tailor Shop		11. BIRTHPLACE (County & State, or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Dominic Esposito					14. MOTHER'S MAIDEN NAME Balbina Adriano				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 615-03-5277A		17. INFORMANT Josephine Esposito (Wife) Address 5625 Lothian Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Chronic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Multiple strokes DUE TO (c) Parkinsonism								INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinsonism								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/3/67 , 19 67 , to 3/8/67 , that (I) (we) lost saw the deceased alive on 3/8/67 , and that death occurred grossly from causes and on the date stated above.									
22a. SIGNATURE W E McGrath				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/10/67			
22c. PHYSICIAN'S NAME (Type) W E McGrath				22d. ADDRESS 1303 Frederick Rd. Catons. 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13-67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) 4430 Belair Rd. Balt. Md.			
24. FUNERAL DIRECTOR Frank DellaNoce				ADDRESS 322 S. High St.		25a. REC'D BY REGISTRAR DATE MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

03196

03286

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03205

CERTIFICATE OF DEATH

03197

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 6500 RIVerview AVENUE	
3. NAME OF DECEASED (Type or print) First EDWIN Middle WILMER Last EWING JR.		4. DATE OF DEATH Month MARCH Day 2 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1898
9. AGE (In years lost birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN W. EWING		14. MOTHER'S MAIDEN NAME SARAH E. JACKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 18 77 19	
17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, RECENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE (c) PULMONARY EMPHYSEMA BRONCHIAL ASTHMA		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 2 , 19 67 to MARCH 2 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 2 , 19 67 , and that death occurred at 1225 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Di Lok Premasathian</i> M.D.		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) DILOK PREMASATHIAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/6/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE PARK NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME		25a. REC'D BY REGISTRAR 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03303

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03206

CERTIFICATE OF DEATH

03198

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (347)		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7829 Wendover Ave.</u>		d. STREET ADDRESS <u>7829 Wendover Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Ellen V. Turner</u>		4. DATE OF DEATH <u>3-20-67</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1888</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Constance</u>		14. MOTHER'S MAIDEN NAME <u>Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Turner 7829 Wendover Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>myocardial infarction</u> (b) <u>myocardial infarction</u> DUE TO <u>myocardial infarction</u> (c) <u>myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>to 3-21-67</u> , 19 <u>that (I) (we) last saw the deceased alive on 3-14-67</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Peake</u>		22b. DATE SIGNED <u>3-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. PEAKE</u>		22d. ADDRESS <u>4508 Hanford Road Balto 21214</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	23d. LOCATION (City or Town) (County) (State) <u>md</u>
24. FUNERAL DIRECTOR <u>Feas Co 7200 Hanford Road</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. DATE <u>MAR 22 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03108

OFFICE OF DEATH

03508

MAR 2 1957

03207

CERTIFICATE OF DEATH

03199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN b 4 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS Washington County Welfare Board			
3. NAME OF DECEASED (Type or print) FEESER, Baby Boy (Billy Friend)				4. DATE OF DEATH Month 3 Day 28 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/25/62	
9. AGE (in years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 28		IF UNDER 24 HRS. Hours 19 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Betty Feeser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral DUE TO (b) Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) institutionalization, Kernicterus, Encephalomyelopathy							
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-20 19 63 to 3-28 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3-28 19 67 , and that death occurred at 6:30 a.m. at the causes and on the date stated above.							
22a. SIGNATURE Richard A Jones				22b. DATE SIGNED 29 Mar 67		22c. PHYSICIAN'S NAME (Type) Richard A Jones	
22d. ADDRESS Rosewood State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/67		23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City, town or county) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR APR 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

03130

HYPER-20 ADVISORY

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3-28

3-30 a.m.

03208

CERTIFICATE OF DEATH

03200

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 46 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7733 Bagley Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle FISCHER Last FISCHER		4. DATE OF DEATH March 27 19 67 Month 21234 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-02 9. AGE (In years last birthday) yrs. 65 IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY TAVERN	11. BIRTHPLACE (County & State, or foreign country) Baltimore 12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME John Fischer		14. MOTHER'S MAIDEN NAME Lillian Morr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-6364 17. INFORMANT Charlotte Fischer Address 7733 Bagley Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, right occipital parietal lobe. DUE TO (b) Hypertensive cardiovascular disease. DUE TO (c) Tumor of right adrenal gland. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 3-22 , 19 67 to 3-27 , 19 67 , that he (we) last saw the deceased alive on 3-27 , 19 67 , and that death occurred at 11:08 AM , from causes and on the date stated above.			
22a. SIGNATURE M.S. Cockburn		22b. DATE SIGNED March 27, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or town) (County) (State) BALTO MD
24. FUNERAL DIRECTOR Chas. T. Evans & Son ADDRESS 8802 Hartford Rd		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00560

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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25M 1/67

6P

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03203

CERTIFICATE OF DEATH

03201

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND			c. LENGTH OF STAY IN lb 27 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1728 N. BENTALOU STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLOYD R. FORD				4. DATE OF DEATH Month Day Year MARCH 2 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 14, 1919	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY CLOTHING COMPANY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FLOYD FORD				14. MOTHER'S MAIDEN NAME MYRTLE GROSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 216 07 47 42		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS DUE TO (b) PANCREATIC CYST WITH RUPTURE INTO ABDOMINAL CAVITY DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY CONGESTION AND EDEMA							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/3/67 , 19__, to 3/2/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/2/67 , 19__, and that death occurred at 6:45 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>J. D. Talbert</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-6-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>Vernon R. Bailey</i>				25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

KELSON FUNERAL HOME
1348 N. CALHOUN ST. BALTIMORE, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03210

CERTIFICATE OF DEATH

03202

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 LORRAINE		d. STREET ADDRESS 403 LORRAINE	
3. NAME OF DECEASED (Type or print) LLOYD B. FOSTER		4. DATE OF DEATH Month MAR. Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 27 1895
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 21 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CO.	
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FOSTER		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES ?		16. SOCIAL SECURITY NO.	
17. INFORMANT MARIE FOSTER		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Post-sclerotic Heart Disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Scabies		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July, 1965 to 3-7-1967 , that (I) (we) last saw the deceased alive on 2-27-1967 , and that death occurred at 1:40 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) WILLIAM K. WONG M.D.		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> CHARLES MONT MEDICAL CENTER	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/10/67	
23c. NAME OF CEMETERY OR CREMATORY LUTHERAN IMMEDIATE		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

0380

07580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03211

03203

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 1281 Cedarcroft Rd.			
3. NAME OF DECEASED (Type or print) Charles Francis				4. DATE OF DEATH Month 3 Day 15 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/15/10	
9. AGE (In years lost birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during life, even if retired) Driver		11. BIRTHPLACE (State or foreign country) Balto. Co.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Herbert E. Francis				14. MOTHER'S MAIDEN NAME Carrie Beall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216 05 7971		17. INFORMANT Address Margaret H. Francis 1281 Cedarcroft Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Artery Disease 24yr (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell				22. DATE SIGNED 3/15/67			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				23. NAME OF CEMETERY OR CREMATORY Camp Chapel Cemetary			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/67		23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.		25a. REC'D BY REGISTRAR MAR 17 1967	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				25b. REGISTRAR'S SIGNATURE [Signature]			

1580

03212

CERTIFICATE OF DEATH

03204

1. PLACE OF DEATH o. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d. STREET ADDRESS 104 Croydon Road 21212	
3. NAME OF DECEASED (Type or print) First Carolyn Estelle Middle Fritz Last 		4. DATE OF DEATH Month March Day 30th. Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	9. AGE (In years last birthday) 70 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Joseph H. Griffie		14. MOTHER'S MAIDEN NAME Elmira Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-0841	
17. INFORMANT Mr. Robert D. Fritz		Address 119 Hedgewood Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive cardiac failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 12 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suppurative pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1955 , to March 1967 , that (I) (we) last saw the deceased alive on March 1967 , and that death occurred at 3:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Frederick J. Vollmer		22b. DATE SIGNED 3/30/67	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		22d. ADDRESS 4100 YORK RD BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.
24. FUNERAL DIRECTOR Wm. J. Trakner & Sons with Pa.		25a. REC'D BY REGISTRAR APR 3 1967	
ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 8709 Baker Avenue	
3. NAME OF DECEASED (Type or print) Jennie		4. DATE OF DEATH Month March Day 28 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-96
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home.	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZENSHIP OF WHAT COUNTRY Italy	
13. FATHER'S NAME Joseph Cantale		14. MOTHER'S MAIDEN NAME Mary Carmeci	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-I8-2983	
17. INFORMANT Mrs. Concetta Lang		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebro-vascular thrombosis or hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 27, 19 67 AM March 28, 19 67 , that (I) (we) last saw the deceased alive on March 28, 19 67 , and that death occurred at 6:25 M, from causes on and on the date stated above.			
22a. SIGNATURE Efraim L. Reyes M.D.		22b. DATE SIGNED March 28, 1967	
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes M.D.		22d. ADDRESS 7620 York Road-Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR Charles Judge	

03802

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FOR STATE HEALTH DEPT.

03214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03206

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb Hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville d. STREET ADDRESS 14 E. Seminary Ave., 21093 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen Boyd Galloway		4. DATE OF DEATH Month March Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct, 12, 1953
9. AGE (In years lost birthday) 13 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T. Merrill Galloway		14. MOTHER'S MAIDEN NAME Audrey Schultz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. T. Merrill Galloway		Address 14 E. Seminary Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Abdominal Hemorrhage DUE TO For Multiple Soft Tissue Trauma DUE TO Depressed Fracture Occiput (RT) Sudden Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9:20--p.m. March 17th 67		20d. INJURY OCCURRED <input type="checkbox"/> While of work <input checked="" type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Lutherville Balto. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 3/17/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/21/67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR MAR 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03215

03207

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MEDICAL CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILY E. GAMSE		4. DATE OF DEATH Month MARCH Day 30 Year 1967	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-87	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 9	
11. IF UNDER 24 HRS. Hours 7 Min. 9		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Jansen		14. MOTHER'S MAIDEN NAME Olga Wolfson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Mrs. Jenny Hoffman		Address 2825 W. Strathmore Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) PULMONARY EMBOLISM DUE TO (c) FRACTURE, RIGHT HIP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE, RIGHT HIP		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. FELL AT HOME		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME	
20c. TIME OF INJURY Month, Day, Year FEB 7, 1967		20d. INJURY OCCURRED While el work <input type="checkbox"/> Not While el work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) PIKESVILLE BALTO. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Baltimore	
ACTUAL SIGNATURE William A. Pillsbury		DATE SIGNED 3/30/67	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		22b. DATE THEREOF 3/31/67	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.		24a. REC'D BY REGISTRAR APR 5 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

03208

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 11 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forrest Haven Nursing Home, Catonsville, Md.				d. STREET ADDRESS School House Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Ernest Gardner				4. DATE OF DEATH Month March Day 13 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1883		9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Consolidated Engineering		11. BIRTHPLACE (County & State, or foreign country) Pikesville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Gardner				14. MOTHER'S MAIDEN NAME Bell Blakeley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen M. Hartley, 809 Milford Mill Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4221 DUE TO HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PULMONARY EDEMA (b) PULMONARY EDEMA (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-1 , 19 66 , to 3-13 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above.							
22a. SIGNATURE John H. Shaw M.D.				22b. DATE SIGNED 3/17/67		22c. PHYSICIAN'S NAME (Type) John H. Shaw M.D.	
22d. ADDRESS 5804 EUNIONDALE AVE. BALDWIN, MD.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.				25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03217

CERTIFICATE OF DEATH

03209

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN lb 10 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home		d. STREET ADDRESS 1908 Hillcrest Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Rochester Glenn		4. DATE OF DEATH Month Day Year March 19 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1883
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Spinner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Glenn		14. MOTHER'S MAIDEN NAME Georgiana Lant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT William J. Glenn - 1908 Hillcrest Rd. #7		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterial sclerosis DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 2, 1967 to Mar 19, 1967 that (I) (we) last saw the deceased alive on Mar 17, 1967 , and that death occurred at 6:30 M, from causes and on the date stated above.			
22a. SIGNATURE Wm. E. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. E. MARTIN		22d. ADDRESS Randallstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-67	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Arcadia, Maryland	
24. FUNERAL DIRECTOR Ellsworth Armacost		25a. REC'D BY REGISTRAR DATE MAR 21 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Jones			

03311

CERTIFICATE OF ANALYSIS

03311

1. Name of the product

2. Name of the manufacturer

3. Name of the analyst

4. Date of analysis

5. Name of the laboratory

6. Name of the client

7. Name of the inspector

8. Name of the analyst

9. Name of the client

10. Name of the inspector

11. Name of the analyst

12. Name of the client

13. Name of the inspector

14. Name of the analyst

15. Name of the client

16. Name of the inspector

17. Name of the analyst

18. Name of the client

19. Name of the inspector

20. Name of the analyst

21. Name of the client

22. Name of the inspector

23. Name of the analyst

24. Name of the client

25. Name of the inspector

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46. Name of the inspector

47. Name of the analyst

48. Name of the client

49. Name of the inspector

50. Name of the analyst

51. Name of the client

52. Name of the inspector

53. Name of the analyst

54. Name of the client

U.S. DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D.C.

03218

CERTIFICATE OF DEATH

03210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore Co. Gen Hosp.</u>		d. STREET ADDRESS <u>4907 Queensberry Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Simon</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Maker (Factory)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARON Goldberg</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-9728</u>	
17. INFORMANT <u>Mrs. Sally Krieger, 6908 Dorsett Place</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, postural wall</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Small Branch</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>67</u> , to <u>3-6</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3-6</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Angela T. Pappas</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANGELITA T. PAPPAS</u>		22d. ADDRESS <u>BOTH, Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Zion</u>		23d. LOCATION (City or Town) (County) (State) <u>Rosedale, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

21560

03510

CERTIFICATE OF DEATH

03219

03211

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Town Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle C. Last Gonce				4. DATE OF DEATH Month March Day 4 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 2, 1902		9. AGE (In years lost birthday) yrs. 65	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laboer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gonce				14. MOTHER'S MAIDEN NAME Lida Lofland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 221-20-8351		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Feb. 25, 19 67 to March 4, 19 67 that we (we) last saw the deceased alive on March 4, 19 67 , and that death occurred at 9:40 M., from causes on and on the date stated above.							
22a. SIGNATURE <i>Stella Wachslar</i>				22b. DATE SIGNED 3-6-67		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Mar 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Townsend Cem.		23d. LOCATION (City or Town) (County) (State) Townsend N.C. Del.	
24. FUNERAL DIRECTOR <i>Heck Name for Funeral, Elkton, Md.</i>				25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11380

11380

11380

Name		Address		City		State		Zip	
John Doe		123 Main St		Springfield		Illinois		62760	
Age		Sex		Race		Religion		Marital Status	
35		Male		White		Catholic		Married	
Education		Occupation		Income		Assets		Liabilities	
High School		Teacher		\$15,000		\$20,000		\$5,000	
Social Security		Health Insurance		Life Insurance		Auto Insurance		Other Insurance	
123-456789		ABC Insurance Co		XYZ Life Ins Co		DEF Auto Ins Co		GHI Other Ins Co	
Signature		Date		Witness		Notary		Remarks	
John Doe		1/1/70		Jane Doe		John Smith		All in good health	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03220

03213

1. PLACE OF DEATH a. COUNTY GBMC Balt. County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) G.B.M.C.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Constance S. Graleska		d. STREET ADDRESS 20 Willow Ave Balto. 21206	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH Month 3 Day 13 Year 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY C.I.A. Wash. D.C.	9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Graleska (dec)		14. MOTHER'S MAIDEN NAME Jeliowski (de)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-1666	
17. INFORMANT Amelia G. Loreless - 20 Willow Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-21-67 to 3/13, 1967 , that (I) (we) last saw the deceased alive on 3-13, 1967 , and that death occurred at 5:04 AM , from the causes and on the date stated above.			
22a. SIGNATURE Ram K. Chhillar		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) RAM K. CHILLAR		22d. ADDRESS GREATER BALTIMORE MED. CENTER BALTIMORE, MD. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/15/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	23d. LOCATION (City, town or county) (State) Balto. Md.
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd.		25a. REC'D BY REGISTRAR MAR 16 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03221

CERTIFICATE OF DEATH

03214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON BALTIMORE		c. LENGTH OF STAY IN 11 DAYS 350 ROSE BANK AVE. BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		d. STREET ADDRESS 350 ROSE BANK AVE.	
3. NAME OF DECEASED (Type or print) ROBERT BUSWELL GRANT		4. DATE OF DEATH 3 27 1967	
5. SEX M	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/22 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENGINEERING METAL CONSTRUCTIONS		11. BIRTHPLACE (County & State, or foreign country) BROOKLYN N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT J. GRANT	
14. MOTHER'S MAIDEN NAME MARY BUSWELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) 1942/1945 212-20-7252	
16. SOCIAL SECURITY NO. 212-20-7252		17. INFORMANT ROBERT J. GRANT Address 328 ST. DUNSTON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-15, 1967 , to 3-27, 1967 , that (I) (we) lost saw the deceased alive on 3-26, 1967 , and that death occurred at 6:45 AM , from causes on and on the date stated above.			
22a. SIGNATURE Mario B. Ines		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) MARIO B. INES M.D.		22d. ADDRESS GBMC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR MAR 28 1967 25b. REGISTRAR'S SIGNATURE J. H. Jenkins	

03222

03212

W. K. K. A. A.

W. K. K. A. A.

W. K. K. A. A.

W. K. K. A. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03222

CERTIFICATE OF DEATH

03215

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 29		c. LENGTH OF STAY IN 1b 17 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5508 Edmondson Avenue		d. STREET ADDRESS 5508 Edmondson Avenue e	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS J. GRIMES		4. DATE OF DEATH Month Day Year March 4, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1880
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Grimes		14. MOTHER'S MAIDEN NAME Catherine Glennon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-4514	
17. INFORMANT Mrs. Elsie M. Grimes		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. S. C. U. Disease. (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Sensitivity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/25, 1967, to 3/4, 1967 that (I) (we) last saw the deceased alive on 3/4, 1967, and that death occurred at 6 PM, from causes and on the date stated above.			
22a. SIGNATURE D. C. MacLaughlin		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin		22d. ADDRESS 303 N. Rolling Rd. 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/1967	
23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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OFFICE OF THE

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UNITED STATES

MAR 8 1967

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b Essex d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1810 Kitty Hawk Road						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 1810 Kitty Hawk Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MINNIE Middle HELEN Last GRIMES						4. DATE OF DEATH Month March Day 30 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1926		9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator				10b. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) N.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Odom						14. MOTHER'S MAIDEN NAME Bertie Strickland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 240-20-7165		17. INFORMANT Address Peggy Grimes 1915 Synder Ave. Balto, Md. 22					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Abdominal hemorrhage DUE TO 983 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Laceration of liver DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Beaten about face, trunk and extremities							
20c. TIME OF INJURY Month, Day, Year Hour 11 min 3-29 p.m. 19 67				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking Lot		20f. (City or town) (County) (State) Baltimore Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Charles S. Petty</i> EXAMINER'S NAME (Type) Charles S. Petty						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rocky Mount, N. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 4/2/67		23c. NAME OF CEMETERY OR CREMATORY Gay-Yost Funeral Home		23d. LOCATION (City or Town) (County) (State) Rocky Mount, N. C.			
24. FUNERAL DIRECTOR <i>Bruzdinski</i> Bruzdinski Funeral Home 1407 Eastern Ave. 21						25a. REC'D BY REGISTRAR DATE APR 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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Barrie Strickland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03224

CERTIFICATE OF DEATH

03217

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1403 Avon Court		d. STREET ADDRESS 1403 Avon Court	
3. NAME OF DECEASED (Type or print) DOROTHY^{First} A. GRIMM^{Middle} Last		4. DATE OF DEATH Month March Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1909
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CASHIER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira Rager		14. MOTHER'S MAIDEN NAME Ida Barnhart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 210-0970-49	
17. INFORMANT Mrs. Ida A. Rager, 1403 Avon Court 21227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Uremia DUE TO (b) Ureteral obstruction metastatic Carcinoma DUE TO (c) Endometrial Carcinoma uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 days 7 mo 2 yrs 7 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1964 , to March 5, 1967 , that (I) (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy		22b. DATE SIGNED 3-5-67	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy		22d. ADDRESS 1264 Francis Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City or Town) (County) (State) Westmont, Johnston Penna.	
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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ORIGINATOR OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03225

03218

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 304 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 5600 Gardenville Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Matthew James GUERIN		4. DATE OF DEATH Month March Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer		10b. KIND OF BUSINESS OR INDUSTRY Continental Oil Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Matthew Guerin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-05-3965	
17. INFORMANT Mary Guerin, wife, above (nee Freyer)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Recurrent Myocardial Infarction DUE TO (c) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that 40 (this hospital) attended the deceased from 2/24/ , 19 67 , to 3/1/ , 19 67 , that 41 (we) last saw the deceased alive on 3/1/ , 19 67 , and that death occurred at 3:45 P., from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik, M.D.		22b. DATE SIGNED March 1, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/4/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR DATE MAR 3 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

03578

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03226					03219					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Baltimore		a. STATE			Penna. 15146		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Catonsville,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Monroeville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
House of Pines Nursing Home					422 Fieldstone Dr.			75-3		
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH			Month Day Year		
Mary Frances Hanzlik					March 13,			19 67		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.		
Female		Caucasian				May 12, 1916		50 yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife						Washington, D. C.			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Arthur E. Maccubbin					Emma Flester					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
no			----		Mr. Henry Hanzlik,			Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 4222 DUE TO (b) <i>Ch. Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple Sclerosis.</i>									INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-18, 1965, to 3-13, 1967, that (I) (we) last saw the deceased alive on 3-13-1967, and that death occurred at 4:25 PM, from the causes and on the date stated above.										
22a. SIGNATURE <i>Wm. K. Gallagher Jr.</i>					22b. DATE SIGNED 3-13-67			22c. PHYSICIAN'S NAME (Type) Wm. K. Gallagher Sr.		
22d. ADDRESS 6209 Frederick Dr. Bost. 21228 Md										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			Mar. 16, 1967		Ivy Hill Cemetery			Laurel, Maryland		
24. FUNERAL DIRECTOR					ADDRESS			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland					DATE MAR 14 1967			<i>J. Charles Judge</i>		

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Alameda

Calaveras Co.

Office of the County Clerk

San Francisco, Cal.

San Francisco, Cal.

July 15, 1910

County of Alameda

San Francisco, Cal.

County of Alameda

Arthur J. Sweeney

San Francisco, Cal.

San Francisco, Cal.

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San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

San Francisco, Cal.

03227

CERTIFICATE OF DEATH

03228

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 5700 East Ave	
3. NAME OF DECEASED (Type or print) John		First Middle Last HARANT		4. DATE OF DEATH Month Day Year March 19 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1887		9. AGE (In years lost birthday) yrs. 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Products		11. BIRTHPLACE (County & State, or foreign country) Austria	
13. FATHER'S NAME John Harant			14. MOTHER'S MAIDEN NAME Theresa Unk		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-3113		17. INFORMANT Philip Harant 5807 Sefton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastro Enteritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Dehydration DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1967 to March 19, 1967 , that (I) (we) last saw the deceased alive on March 19, 1967 , and that death occurred at 1:30 am , from causes on and on the date stated above.					
22a. SIGNATURE Regalado T. Dizon M.D.				22b. DATE SIGNED March 19, 1967	
22c. PHYSICIAN'S NAME (Type) Regalado T. Dizon M.D.				22d. ADDRESS 7620 York Rd. Towson 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
		23d. LOCATION (City or Town) 4430 Belair Road		(County) (State) Md	
24. FUNERAL DIRECTOR The Dippel Brothers Inc 7110 Belair Road				25a. REC'D BY REGISTRAR MAR 21 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03228					03221				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2815 Garnet Road					d. STREET ADDRESS 2815 Garnet Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle N. Last Harple					4. DATE OF DEATH Month 3 Day 13 Year 1967				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1912		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 03 Days -1	IF UNDER 24 HRS. Hours 00 Min. 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. Fire Dept.			10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John C. Harple					14. MOTHER'S MAIDEN NAME Christina Schlissler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 212-01-1531		17. INFORMANT Alma M. Henning Address Sane				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 3-13 , 19 67 , that (I) (we) last saw the deceased alive on 3-10 19 67 , and that death occurred at 2:30 M, from the causes and on the date stated above.									
22a. SIGNATURE Harold H. Burns					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-15-1967		
22c. PHYSICIAN'S NAME (Type) Harold H. Burns					22d. ADDRESS 8106 Harford Road				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-16-1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town or county) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Chas. F. Evans, Son					ADDRESS 8802 Harford Rd		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge

03332

03332

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03229

CERTIFICATE OF DEATH

03222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 30-4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1332 N. EDEN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FOREST HARRIS First Middle Last 4. DATE OF DEATH 3 Month 12 Day Year 1967		5. SEX MALE 6. COLOR OR RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 2/5/98 9. AGE (In years last birthday) yrs. 68 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME SARAH CUNNINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 228-16-7371	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Second degree A-V Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Artery Heart Disease (b) Second degree A-V Block (c) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0 Casepro - Vascular Accident of old Pul. Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 66 to 3-12 , 19 67 , that (I) (we) last saw the deceased alive on 3/12 , 19 67 , and that death occurred at 2:08 M, from causes and on the date stated above.		22a. SIGNATURE Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland 22b. DATE SIGNED 3/12/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland		22d. ADDRESS At Calvary Cemetery, Anne Arundel Ctry., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY At Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Anne Arundel Ctry., Md.	
24. FUNERAL DIRECTOR William C. March 928 E. North Ave.		25a. REC'D BY REGISTRAR MAR 14 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

03232

TESTIMONY OF DEATH

03232

11th June 1947

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03230 CERTIFICATE OF DEATH 03223											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 7602 Brooklyn Bridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Teresa Middle Lynn Last HAYWOOD						4. DATE OF DEATH Month 3 Day 10 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/23/62		9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Cumberland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Noel Haywood						14. MOTHER'S MAIDEN NAME ORNDORFF, Patricia Ann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Rosewood Records Owings Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric & urinary bladder distension & fecal impaction (c) institutionalization due to Kernicterus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) institutionalization due to Kernicterus INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 3				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that if (this hospital) attended the deceased from 3-10 , 1966, to 3-10 , 1967, that (we) last saw the deceased alive on 3-10 1967, and that death occurred at 11:30 AM , from the causes and on the date stated above.											
22a. SIGNATURE Richard A. Jones						22b. DATE SIGNED 10 Mar 67					
22c. PHYSICIAN'S NAME (Type) Richard A. Jones						22d. ADDRESS Rosewood State Hosp.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/13/67		23c. NAME OF CEMETERY OR CREMATORY St. Peters			23d. LOCATION (City, town or county) (State) Westernport, Md.		
24. FUNERAL DIRECTOR W. J. Bural						25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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03231

CERTIFICATE OF DEATH

03224

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale 21207		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale 21207	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3526 St. James Road			d. STREET ADDRESS 3526 St. James Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) C. McLean Hayworth			4. DATE OF DEATH Month March Day 5 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Transit		11. BIRTHPLACE (County & State, or foreign country) Blue Island, Cooks Co. Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Walter Hayworth		
14. MOTHER'S MAIDEN NAME Lillie May Shoppert			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-25-9228			17. INFORMANT Address Mrs. Mary E. Hayworth-3526 St. James Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Acute myocardial failure DUE TO (b) Acute lobular pneumonia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3/5/67 3/1/67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/67 , 19 67 , to 3/5 , 19 67 , that (I) (we) last saw the deceased alive on 3/5 , 19 67 , and that death occurred on 3/5 M, from causes and on the date stated above					
22a. SIGNATURE Benjamin Siegel			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/67
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Siegel			22d. ADDRESS 15 Greenwood Rd. Balt., Md. 21208		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/8/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown,			25a. REC'D BY REGISTRAR MAR 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03232

CERTIFICATE OF DEATH

03225

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		c. LENGTH OF STAY IN lb <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Medical Baltimore Center</u>		d. STREET ADDRESS <u>215 Sandee Road</u>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>H</u> Middle <u>Hazel</u> Last		4. DATE OF DEATH <u>3</u> Month <u>30</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>82</u> 9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Atlanta, GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adison</u> <u>Hook</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Isabelle Lake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-7309</u>	
17. INFORMANT <u>Paul H King</u> Address <u>Same as #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Emphysema - putrefactive type - of the liver</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>67</u> , to <u>3/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> , 19 <u>67</u> , and that death occurred at <u>12:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Derek A Bruce</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>		22d. ADDRESS <u>G. B. M. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d. LOCATION (City or Town) (County) (State) <u>Parkville, Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

05825

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03233

CERTIFICATE OF DEATH

03226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b Parkville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8312 Overmont Road		d. STREET ADDRESS 8312 Overmont Road	
3. NAME OF DECEASED (Type or print) GRACE R HEILMAN		4. DATE OF DEATH Month 3 Day 26 Year 67	
5. SEX f	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/30/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office clerk retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Joseph Switzer		14. MOTHER'S MAIDEN NAME Catherine Duval	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-4846	
17. INFORMANT no		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arterio-sclerosis, chronic myocarditis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1920 , 19, to 3/26/67 , 19, that (I) (we) last saw the deceased alive on 3/25/67 , 19, and that death occurred at 2 P M, from causes and on the date stated above.			
22a. SIGNATURE A. Callas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Andres E Callas		22d. ADDRESS 6411 Frederick Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.
24. FUNERAL DIRECTOR CHAS. F. EVANS & SON 8802 Harford Rd		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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CERTIFICATE OF DEATH

03227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (rural) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1637 Mussula Road...21204		d. STREET ADDRESS 1637 Mussula Road--21204	
3. NAME OF DECEASED (Type or print) First HENRY A. Middle HEMING Last		4. DATE OF DEATH Month March Day 27 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1877.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationary Eng.		10b. KIND OF BUSINESS OR INDUSTRY American Smelting Co.	11. BIRTHPLACE (County & State, or foreign country) Holland
13. FATHER'S NAME John Heming		14. MOTHER'S MAIDEN NAME Katherine ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-1472	
17. INFORMANT Mrs. Catherine B. Heming		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic CVD, Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic CVD, Severe DUE TO (c) Arteriosclerotic CVD, Severe			INTERVAL BETWEEN ONSET AND DEATH 4 days 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular Insufficiency			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to March 27, 1967 , that (I) (we) last saw the deceased alive on March 24, 1967 , and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Joseph F. LiPira		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph F. LiPira		22d. ADDRESS 8400 Loch Raven Blvd., 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md.--21214		25a. REC'D BY REGISTRAR DATE MAR 28 1967	25b. REGISTRAR'S SIGNATURE J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03334

EXHIBIT 10-03334

03334

1. Name of the person or organization		2. Address	
3. City		4. State	
5. Zip		6. Telephone	
7. Date		8. Signature	
9. Title		10. Organization	
11. Subject		12. Remarks	
13. Date		14. Signature	
15. Title		16. Organization	
17. Subject		18. Remarks	
19. Date		20. Signature	
21. Title		22. Organization	
23. Subject		24. Remarks	
25. Date		26. Signature	
27. Title		28. Organization	
29. Subject		30. Remarks	
31. Date		32. Signature	
33. Title		34. Organization	
35. Subject		36. Remarks	
37. Date		38. Signature	
39. Title		40. Organization	
41. Subject		42. Remarks	
43. Date		44. Signature	
45. Title		46. Organization	
47. Subject		48. Remarks	
49. Date		50. Signature	
51. Title		52. Organization	
53. Subject		54. Remarks	
55. Date		56. Signature	
57. Title		58. Organization	
59. Subject		60. Remarks	
61. Date		62. Signature	
63. Title		64. Organization	
65. Subject		66. Remarks	
67. Date		68. Signature	
69. Title		70. Organization	
71. Subject		72. Remarks	
73. Date		74. Signature	
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77. Subject		78. Remarks	
79. Date		80. Signature	
81. Title		82. Organization	
83. Subject		84. Remarks	
85. Date		86. Signature	
87. Title		88. Organization	
89. Subject		90. Remarks	
91. Date		92. Signature	
93. Title		94. Organization	
95. Subject		96. Remarks	
97. Date		98. Signature	
99. Title		100. Organization	

1. Name of the person or organization

2. Address

3. City

4. State

5. Zip

6. Telephone

7. Date

8. Signature

9. Title

10. Organization

11. Subject

12. Remarks

13. Date

14. Signature

15. Title

16. Organization

17. Subject

18. Remarks

19. Date

20. Signature

21. Title

22. Organization

23. Subject

24. Remarks

25. Date

26. Signature

27. Title

28. Organization

29. Subject

30. Remarks

31. Date

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33. Title

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36. Remarks

37. Date

38. Signature

39. Title

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44. Signature

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49. Date

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90. Remarks

91. Date

92. Signature

93. Title

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95. Subject

96. Remarks

97. Date

98. Signature

99. Title

100. Organization

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03235

03228

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7108 Plymouth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE First Middle Last J. Johanna HERETICK		4. DATE OF DEATH Month March Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH 3/27/08
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Mm. IF UNDER 24 HRS. Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Records		10b. KIND OF BUSINESS OR INDUSTRY Seton Institute	
11. BIRTHPLACE (State or foreign country) Homeville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Heretick		14. MOTHER'S MAIDEN NAME Margaret A. Hucik	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Miss Otilia Heretick, 7108 Plymouth Road, Pikesville 8, Md.		18. ADDRESS	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Gunshot wounds of chest DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Shot by unknown assailant	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 3/2/ 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Pikesville, Baltimore, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED March 3, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county) March 3, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 6, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery	23d. LOCATION (City or Town) (County) (State) Pikesville 8, Md.
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.		25. REGISTRY SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03229

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix/Towson		c. LENGTH OF STAY IN lb 23 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix <i>13-1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS Phoenix Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. Hicks				4. DATE OF DEATH Month Day Year March 7 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1902		9. AGE (In years last birthday) 65 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Asst.		10b. KIND OF BUSINESS OR INDUSTRY Bendix Radio		11. BIRTHPLACE (State or foreign country) Lower Makefield, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Hicks				14. MOTHER'S MAIDEN NAME Mary Elizabeth Sternberger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-03-5485		17. INFORMANT Mrs. M. Hicks Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 11, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		23d. LOCATION (City or Town) (County) (State) Texas, Baltimore Ct., Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson				25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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03237

CERTIFICATE OF DEATH

03230

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY RANDALLSTOWN BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLTOWN		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GENERAL HOSP.		d. STREET ADDRESS BOX 148 OLD COURTRD	
3. NAME OF DECEASED (Type or print) ARTHUR First Middle R. Last HIGGS		4. DATE OF DEATH Month MARCH Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/82
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) PAGE County, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIGGS-JACOB		14. MOTHER'S MAIDEN NAME PAINTER,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-3948	
17. INFORMANT Shay Higgs - M.L. Cary Rte. 2. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1-2 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/27/67 DOA to 3/27/67 , 19 67 , that (I) (we) last saw the deceased alive on 3/27/67 and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Ronald Berger		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) DR. RONALD BERGER		22d. ADDRESS BALTO. COUNTY HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City or Town) (County) (State) Randallstown, Md.
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR MAR 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03330

CERTIFICATE OF DEATH

03330

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03239

CERTIFICATE OF DEATH

03232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		d. STREET ADDRESS <u>3 Contact Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROSEWOOD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>McKinley III</u> Last <u>Hilliard</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-43</u>
9. AGE (In years lost birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William McKinley Hilliard</u>		14. MOTHER'S MAIDEN NAME <u>Nana Lenore Boges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, orthostatic</u> <u>491X</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inst. tubercularization due to Congenital Mental Deficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (if this hospital) attended the deceased from <u>Aug. 27, 1963</u> , to <u>Mar. 8, 1967</u> , that (we) last saw the deceased alive on <u>Mar. 8, 1967</u> , and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Jones</u>		22b. DATE SIGNED <u>9 Mar 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones</u>		22d. ADDRESS <u>Rosewood State Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>John G. Connolly Sons</u>		25a. MARYLAND REGISTRATION DATE <u>3/9/67</u>	
ADDRESS <u>Essex Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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1. NAME OF VESSEL		2. TYPE OF VESSEL		3. HOME PORT	
4. DATE OF DEPARTURE		5. DATE OF RETURN		6. DURATION OF TRIP	
7. NAME OF CAPTAIN		8. NAME OF COMMANDER		9. NAME OF SURGEON	
10. NAME OF ENGINEER		11. NAME OF BOATSWAIN		12. NAME OF CUNTER	
13. NAME OF QUARTERMASTER		14. NAME OF CHIEF OF ENGINE		15. NAME OF CHIEF OF CUNTER	
16. NAME OF CHIEF OF BOAT		17. NAME OF CHIEF OF ENGINE		18. NAME OF CHIEF OF CUNTER	
19. NAME OF CHIEF OF BOAT		20. NAME OF CHIEF OF ENGINE		21. NAME OF CHIEF OF CUNTER	
22. NAME OF CHIEF OF BOAT		23. NAME OF CHIEF OF ENGINE		24. NAME OF CHIEF OF CUNTER	
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52. NAME OF CHIEF OF BOAT		53. NAME OF CHIEF OF ENGINE		54. NAME OF CHIEF OF CUNTER	
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64. NAME OF CHIEF OF BOAT		65. NAME OF CHIEF OF ENGINE		66. NAME OF CHIEF OF CUNTER	
67. NAME OF CHIEF OF BOAT		68. NAME OF CHIEF OF ENGINE		69. NAME OF CHIEF OF CUNTER	
70. NAME OF CHIEF OF BOAT		71. NAME OF CHIEF OF ENGINE		72. NAME OF CHIEF OF CUNTER	
73. NAME OF CHIEF OF BOAT		74. NAME OF CHIEF OF ENGINE		75. NAME OF CHIEF OF CUNTER	
76. NAME OF CHIEF OF BOAT		77. NAME OF CHIEF OF ENGINE		78. NAME OF CHIEF OF CUNTER	
79. NAME OF CHIEF OF BOAT		80. NAME OF CHIEF OF ENGINE		81. NAME OF CHIEF OF CUNTER	
82. NAME OF CHIEF OF BOAT		83. NAME OF CHIEF OF ENGINE		84. NAME OF CHIEF OF CUNTER	
85. NAME OF CHIEF OF BOAT		86. NAME OF CHIEF OF ENGINE		87. NAME OF CHIEF OF CUNTER	
88. NAME OF CHIEF OF BOAT		89. NAME OF CHIEF OF ENGINE		90. NAME OF CHIEF OF CUNTER	
91. NAME OF CHIEF OF BOAT		92. NAME OF CHIEF OF ENGINE		93. NAME OF CHIEF OF CUNTER	
94. NAME OF CHIEF OF BOAT		95. NAME OF CHIEF OF ENGINE		96. NAME OF CHIEF OF CUNTER	
97. NAME OF CHIEF OF BOAT		98. NAME OF CHIEF OF ENGINE		99. NAME OF CHIEF OF CUNTER	
100. NAME OF CHIEF OF BOAT		101. NAME OF CHIEF OF ENGINE		102. NAME OF CHIEF OF CUNTER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03240

CERTIFICATE OF DEATH

03233

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring (Rural)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1109 Mace Avenue				d. STREET ADDRESS 1109 Mace Avenue		13-1	
3. NAME OF DECEASED (Type or print) First Helen Middle Elizabeth Last Hilmer				4. DATE OF DEATH Month 3 Day 5 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1876		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Wendroth				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-50-9187		17. INFORMANT Mrs. Barbara Hilmer		Address 1109 Mace Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure 443X DUE TO (b) Heart failure, chronic, left sided DUE TO (c) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 8 hours 10 yrs 11 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1958 to March 5, 1967 , and that (I) was saw the deceased alive on March 5, 1967 , and that death occurred at 4 P.M. from causes and on the date stated above.							
22a. SIGNATURE Eugene C. Baumann, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) EUGENE C. BAUMANN				22d. ADDRESS 413 Eastern Ave., Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-1967		23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Golden Ring Baltimore Md.	
24. FUNERAL DIRECTOR Lessaahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR 36 DATE MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

03230

UNITED STATES OF AMERICA

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03238						03231					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY BALTIMORE			MARYLAND			a. STATE MARYLAND			b. COUNTY BALTIMORE		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 1 Day			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21212			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home						d. STREET ADDRESS 4402 Marble Hall Road					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Mary		Middle Helen		Last Hihn		Month March		Day 6		Year 19 67	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1890		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore County Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Seth Daily						14. MOTHER'S MAIDEN NAME Frances Carr					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-01-7840		17. INFORMANT 4402 Marble Hall Road 21212 Dr. J. Bernard Hihn Sr.					
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hobart pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of left breast</u> (a), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from....., 1965 to March 6, 1967, that (I) (we) last saw the deceased alive on March 6, 1967, and that death occurred at 6 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Henry Haase</u>						22b. DATE SIGNED March 7, 1967					
22c. PHYSICIAN'S NAME (Type) J. Henry Haase						22d. ADDRESS 2926 East Cold Spring Avenue					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF March 9, 1967			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.						25a. REC'D BY REGISTRAR MAR 13 1967			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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THE UNIVERSITY OF CHICAGO

* 6-10-2007

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03241

CERTIFICATE OF DEATH

03234

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>5408 CLOVER ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Fannie Hoffman</u>		4. DATE OF DEATH <u>March 5, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>89 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>
13. FATHER'S NAME <u>HARRY OVRUTSKY</u>		14. MOTHER'S MAIDEN NAME <u>PAULA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MR. LEON HOFFMAN</u>		Address <u>3415 WASHINGTON AVENUE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> (b) <u>& hypertension</u> DUE TO <u>hypertension</u> (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 15 hrs</u> <u>about 20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (This hospital) attended the deceased from <u>Wed, 1965</u> to <u>Wed 4, 1967</u> that (I) (we) last saw the deceased alive on <u>3/4</u> 1967, and that death occurred at <u>1:55 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Dr. Herman Seidel</u>		22b. DATE SIGNED <u>March 5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERMAN SEIDEL</u>		22d. ADDRESS <u>2401 Eutaw Place</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar 6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, MD</u>
24. FUNERAL DIRECTOR <u>Sal Geunnon Inc</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	
ADDRESS <u>6010 Reister Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

03242

CERTIFICATE OF DEATH

03235

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plum Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS Box 265 Huntington Rd.,	
3. NAME OF DECEASED (Type or print) First Cleveland Middle Matthew Last Holland		4. DATE OF DEATH Month 3 Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/61
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR Months 5 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Calvert Co. Hosp.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew C. Holland		14. MOTHER'S MAIDEN NAME Jones, Doris Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rosewood Records		Address Owings Mill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic Meningoencephalomyelitis due to staphylococcus (c) Chronic Meningoencephalomyelitis due to staphylococcus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(d))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that this (this hospital) attended the deceased from Feb. 7, 1963 , to Mar. 11, 1967 , that it (we) last saw the deceased alive on March 11, 1967 , and that death occurred at 10:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Lucrecia F. Joven		22b. DATE SIGNED Mar. 11, 1967	
22c. PHYSICIAN'S NAME (Type) Lucrecia F. Joven M.D.		22d. ADDRESS Rosewood State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-14-67	23c. NAME OF CEMETERY OR CREMATORY Plum Point Church	23d. LOCATION (City or Town) (County) (State) Plum Point Calvert Md.
24. FUNERAL DIRECTOR George E. Berry-Huntington		25. REC'D BY REGISTRAR MAR 14 1967	
26. REGISTRAR'S SIGNATURE John E. Berry		27. REGISTRAR'S SIGNATURE John E. Berry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 L/6/67 DC

03243

CERTIFICATE OF DEATH

03236

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN lb <u>2 yrs 7 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills,</u>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in The Pines - 15 FUSTING Ave</u>				d. STREET ADDRESS <u>Luthe Lane Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE F.</u> Middle <u>HOLLAND</u> Last <u>HOLLAND</u>				4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 23 1891</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lin Decorating Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Art Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John G. Holland</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Barbie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Alan L Mc Gehee Owings Mills</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>1037</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-26-1964</u> , to <u>3-31-1967</u> , that (I) (we) last saw the deceased alive on <u>3-31-1967</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u>				22d. ADDRESS <u>6207 Frederick Ave. Baltimore 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md.</u>	
24. FUNERAL DIRECTOR <u>Henry J. Eckhardt</u>				ADDRESS <u>Owings Mills, Md.</u>		25a. READ BY REGISTRAR DATE <u>APR 4 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03330

DEPT. OF AGRICULTURE

03330

James H. Harkness
Cincinnati, Ohio

Oct 23 1891

Mr. Harkness

Dear Sir:
I have the pleasure to acknowledge the receipt of your letter of the 18th inst. in relation to the matter of the

to be made by
John H. Harkness
Cincinnati, Ohio

Yours very truly,
J. H. Harkness

03244

CERTIFICATE OF DEATH

03237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE New Jersey b. COUNTY Union	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Lutherville		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Seminary Ave.		d. STREET ADDRESS One Euclid Ave	
3. NAME OF DECEASED (Type or print) Laura Everett Hood		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1883
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin A. Bentley		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ???	
17. INFORMANT Walter B. Everett		Address 11 River Glen Road Hasting on the Hudson, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10, 1960 , to March 22, 1967 , that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Laurence C. Post, M. D.		22d. ADDRESS 6805 York Road, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 25 1967	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Elizabeth, New Jersey	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,		25a. REC'D BY REGISTRAR MAR 27 1967	
ADDRESS 1050 York Road Towson, Maryland 21204		25b. REGISTRAR'S SIGNATURE Charles Judge	

03533

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RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03245

CERTIFICATE OF DEATH

03238

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2904 Cub Hill Road				d. STREET ADDRESS 2904 Cub Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle MAE Last HOOPER				4. DATE OF DEATH Month March Day 15 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1880	
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Beedle				14. MOTHER'S MAIDEN NAME Georgiana G. Waldtjen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-09-1204D		17. INFORMANT Mrs. Gertrude Welsh Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO Congestive Failure (b) Intercerebral CVA DUE TO Generalized metastatic malignancy (c) Primary site Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1967 , to Mar 15, 1967 that (I) (we) lost saw the deceased alive on Mar 15, 1967 , and that death occurred at 11:50 A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Willard Applefold</i> M.D.				22b. DATE SIGNED 3/16/67		22c. PHYSICIAN'S NAME (Type) Willard Applefold	
22d. ADDRESS 5901 Park Heights Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR MAR 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03246					03239				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 03-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOME: 621 Chestnut Avenue					d. STREET ADDRESS 621 Chestnut Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STUART		First STUART		Middle CATOR		Last HOPPER		4. DATE OF DEATH Month March Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1884		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel W. T. Hopper					14. MOTHER'S MAIDEN NAME Sallie Cator				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. WW 1 & 11		17. INFORMANT: wife		Address Towson, 21204		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate					INTERVAL BETWEEN ONSET AND DEATH 5 days 3 years				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 2, 1967 to March 8, 19 67 that (I) (we) last saw the deceased alive on March 8, 19 67 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE C. Stuenkel Boyd M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 9, 1967		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Mar. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., Balto.					ADDRESS 21201		25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

03330

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MAKING A COPY
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03247

CERTIFICATE OF DEATH

03240

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1133 Orems Rd</u>		d. STREET ADDRESS <u>1133 Orems Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur H. Hopson</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>4th</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 December 1880</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jason H. Hopson</u>		14. MOTHER'S MAIDEN NAME <u>Nannie A. Troutman (deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>arterio-sclerotic cardiovascular disease with acute failure</u> DUE TO <u>disease with acute failure</u> DUE TO <u>stating the underlying cause last.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>March 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 19 <u>67</u> , and that death occurred at <u>5 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenov</u>		22b. DATE SIGNED <u>March 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		22d. ADDRESS <u>2108 OREMS RD BACTO 20, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopson Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Mitchell Co. N. Carolina</u>
24. FUNERAL DIRECTOR <u>Connolly Funeral Home - 300 Prince Ave</u>		25a. REC'D BY REGISTRAR DA <u>MAR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03580

STATEMENT OF WORK

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STATEMENT OF WORK

03580

03248

CERTIFICATE OF DEATH

03241

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Kenwood Avenue		d. STREET ADDRESS 4500 Kenwood Avenue	
3. NAME OF DECEASED (Type or print) Alice M. Hunt		4. DATE OF DEATH Month 3 Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) W. Va. Huntington		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-07-1169D	
17. INFORMANT Mrs John Mergler 6008 Westwood Avenue 6		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerosis cardio vasculadisa DUE TO (c) 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966 to March 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 7:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Charles M. Kerr		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles M. Kerr		22d. ADDRESS 6801 Belair Rd J Balto G.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery Baltimore Co. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Taasahn Funeral Home 7401 Belair Rd		25a. REC'D BY REGISTRAR DATE 9 20 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03249

CERTIFICATE OF DEATH

03242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH COUNTY <u>Baltimore County - 28</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton - Ridge Nursing Home</u>		d. STREET ADDRESS <u>1225 Handbert St</u>	
3. NAME OF DECEASED (Type or print) <u>Julia</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>78</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Valeti' Pavlowski</u>		14. MOTHER'S MAIDEN NAME <u>M. Knapp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Julia Kelly</u>		Address <u>1225 Handbert St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCD.</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Pyelonephritis.</u> DUE TO (c) <u>Leukemia.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/6/67, 1967</u> , to <u>3/7/67, 1967</u> ; that (I) (we) last saw the deceased alive on <u>3/7/67, 1967</u> , and that death occurred at <u>6:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arnold M. Allieborg</u>		22b. DATE SIGNED <u>3/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arnold M. Allieborg MD</u>		22d. ADDRESS <u>8155 Loch Raven Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis, Md.</u>
24. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>1501 E. Fort Avenue.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 8 1967</u>	

SASEO

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03250

CERTIFICATE OF DEATH

03243

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1033 Courtney Road		d. STREET ADDRESS 1033 Courtney Road	
3. NAME OF DECEASED (Type or print) Bernard H. Johnson, Sr.		4. DATE OF DEATH Month March Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1910
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bradley T. Johnson, Sr.		14. MOTHER'S MAIDEN NAME Mary C. Faegans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-1756	
17. INFORMANT Mr. Bernard Johnson, Jr.		Address 1033 Courtney Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Generalized - DUE TO (b) Primary Site - Lung - DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from year 1957 , to 3/14, 1967 , that (I) (we) lost the deceased alive on 3/14 1967 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE James M. Frederick		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. James M. Frederick		22d. ADDRESS 1311 Francis Avenue, Balto., Md. 27	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-17-1967	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City or Town) (County) (State) Howard County, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE MAR 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

03245

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeyville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Homes</u>		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>—</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 14, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTH PLACE (County & State, or foreign country) <u>Somerset, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William E. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-54-9692</u>	
17. INFORMANT <u>Records of Md. Masonic Homes, Cockeyville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Chronic Brain Syndrome</u> DUE TO (c) <u>Advanced Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 1965</u> to <u>Feb 27, 1967</u> that (I) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>JAMES H. HAMED</u>		22b. DATE SIGNED <u>March 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MARCH 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Marion, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

03246

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN lb <u>Overlea</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4339 Glenmore Ave.</u>		d. STREET ADDRESS <u>4339 Glenmore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Marie</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-11-1885</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Kaiss</u>		14. MOTHER'S MAIDEN NAME <u>Caroline L. Letmate</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220302919</u>	
17. INFORMANT <u>Mrs Ralph Veara</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>A.S.U.D.</u> DUE TO (c) <u>Cerebral Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u> </u> , to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/66</u> , 19 <u> </u> , and that death occurred at <u>3:00</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Karpf</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. KARPFIN</u>		22d. ADDRESS <u>4331 Heaped Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/23/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03254

03247

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Hrs. 5Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L Last JONES		4. DATE OF DEATH Month MARCH Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/08
9. AGE (In years last birthday) yrs. 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Jones		14. MOTHER'S MAIDEN NAME Margaret Grantland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 221-05-86-31	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Meningitis DUE TO (b) Pneumonia DUE TO (c) Uremia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17, 1967 , to March 17, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 17, 1967 , and that death occurred at 10:30 PM from causes and on the date stated above			
22a. SIGNATURE Z. S. Tao		22b. DATE SIGNED 3/19/67	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Zannino Funeral Home		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

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6 Hrs. Day

Port Harour

Veterans Administration Hospital 111 Third Street

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WATSON

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10-10-1948

White

Male

U.S.A.

Washington, D.C.

Security

United States

Married

United States

Yes 17-10-1948 111 Third Street, Port Harour, WA

Type

Personal Information

Date

Personal

By

Private

Washington, D.C.

17-10-1948 111 Third Street, Port Harour, WA

10:30 AM

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17-10-1948

17-10-1948 111 Third Street, Port Harour, WA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03255

CERTIFICATE OF DEATH

03248

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 6702 Glenkirk Avenue	
3. NAME OF DECEASED (Type or print) First Maud Middle Louise Last Kane		4. DATE OF DEATH Month March Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-91
9a. AGE (In years last birthday) 16 15 yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Scranton, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Burke		14. MOTHER'S MAIDEN NAME Jane Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 159055257B	
17. INFORMANT Mrs Bernard Norton		Address 6702 Glenkirk Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Core pulmonale DUE TO (b) Severe fibrosis of left lung. DUE TO (c) Severe fibrosis of left lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 5, 19 67 to March 6, 19 67 that (I) (we) last saw the deceased alive on March 6, 19 67 , and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE M.S. Cockburn MD		22b. DATE SIGNED March 6, 1967.	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-10-67	23c. NAME OF CEMETERY OR CREMATORY Holy Sepulcher Cem.	23d. LOCATION (City or Town) (County) (State) Phialdelphia, Penna.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		25a. REC'D BY REGISTRAR DR R 9 1967	25b. REGISTRAR'S SIGNATURE J Charles Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03256

CERTIFICATE OF DEATH

03249

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital	
d. STREET ADDRESS 6307 Hamilton Avenue 21206		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Karp Last Karp		4. DATE OF DEATH Month March Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-82
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul German		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-3179	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Feeding problem - Chronic Brain Syndrome associated with Cerebral Arteriosclerosis with psychotic features.			
19. INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-11-63 , 19__, to 3-9-67 , 19__, that (I) (we) last saw the deceased alive on 3-9-67 , 19__, and that death occurred at 1:20 M, from causes and on the date stated above.			
22a. SIGNATURE Evelio A. Felipe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe		22d. ADDRESS Spring Grove State Hospital 1 Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-1967	
23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Golden Ring Balto. Md.	
24. FUNERAL DIRECTOR Laasah Funeral Home 7901 Belair Rd		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03257

03250

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 51yr5mth23dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. STREET ADDRESS 1239 Glenhaven Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Margaret Middle Kernan Last Kernan		4. DATE OF DEATH Month March Day 30 Year 1967			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1889	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Michael Kernan			14. MOTHER'S MAIDEN NAME Isabell Ackenback		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-54-3188T		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition - Chronic brain syndrome associated with generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1965 to March 30, 1967 , that (I) (we) last saw the deceased alive on March 30, 1967 , and that death occurred at 2:45 M, from the causes and on the date stated above.					
22a. SIGNATURE Evelio A. Felipe, M.D.		22b. DATE SIGNED 3-30-67		22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.	
22d. ADDRESS Baltimore, Maryland 21228		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR McCook - Brooks Inc.		ADDRESS 1217 St. Paul Street		25a. REC'D BY REGISTRAR APR 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED DE BEATH

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CERTIFICATE OF DEATH

03251

03258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) G. B. M. C.			d. STREET ADDRESS Charles Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GREGORY G. Kiehne			4. DATE OF DEATH Month 3 Day 4 Year 1967		
5. SEX M.	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1885		9. AGE (In years lost birthday) yrs. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RL. Priest		10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, Md.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME HERMAN H. KIEHNE		
14. MOTHER'S MAIDEN NAME MARY C. NELSON			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT REV. McNAMARA BOYCE AVE. -21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-Resp. Failure DUE TO (b) Cancer of Lung DUE TO (c) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/24/67 , 19 67 , to 3/4/ , 19 67 , that (I) (we) lost saw the deceased alive on 3/4 19 67 , and that death occurred at 3:40 AM, from causes on and on the date stated above.					
22a. SIGNATURE Dennis Chan		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) DENIS CHAN. M.D.		22d. ADDRESS GREATER BALTO. MED. CENTER			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 7/67	23c. NAME OF CEMETERY OR CREMATORY WOODSTOCK COLLEGE		23d. LOCATION (City or Town) (County) (State) WOODSTOCK BALTIMORE, MD	
24. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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BRENNAN H. LITTON

JOYCE HIGH SCHOOL
JOYCE, MICHIGAN JOYCE AVE. - 31204

BRENNAN H. LITTON

POSTAL MARCH 1887
H.W. HARRIS & SON 905 N. CALIFORNIA ST. MAR 3 1887

WOODSTOCK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 11/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03259

CERTIFICATE OF DEATH

03252

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5464 Addington Road</u>		d. STREET ADDRESS <u>5464 Addington Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Louis E. Kimmel Sr.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11 1895</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kimmel</u>		14. MOTHER'S MAIDEN NAME <u>Regina Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Louis E. Kimmel</u>		Address <u>5464 Addington Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR THROMBOSIS.</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>DEC.</u> , 19 <u>60</u> , to <u>MARCH 7, 1967</u> , that (I) (we) las saw the deceased alive on <u>MARCH 6, 1967</u> , and that death occurred at <u>3 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Norman R. Kleiman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/8/67</u>
22c. PHYSICIAN'S NAME (Type) <u>NORMAN R. KLEIMAN</u>		22d. ADDRESS <u>3803 EDMONDSON AVE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F.D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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RECEIVED OF DEATH

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RECEIVED OF DEATH

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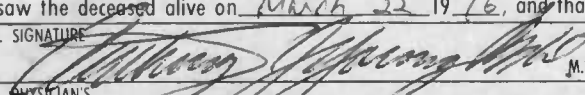
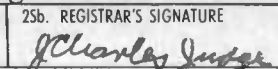
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03260		CERTIFICATE OF DEATH		03253	
1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			d. STREET ADDRESS 7622 Goodland Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Kirker Sr			4. DATE OF DEATH Month March Day 22 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1-26-90		9. AGE (In years last birthday) yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brickmason		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Mass.	
13. FATHER'S NAME Thomas Kirker			14. MOTHER'S MAIDEN NAME Margaret		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-09--117		17. INFORMANT Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, organism unknown, left lower lobe DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 490X					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from 11-1-66 , 19 to March 22, 1967 , that (he) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 7:45 AM , from causes and on the date stated above.					
22a. SIGNATURE 			22b. DATE SIGNED 3-22-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.
22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
23d. LOCATION (City or Town) Washington D C					
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE 

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

BP

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03261 CERTIFICATE OF DEATH 03251											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> 03-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1955 Walnut Avenue</u>						d. STREET ADDRESS <u>1955 Walnut Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>J.</u> Last <u>KOWALSKI</u>						4. DATE OF DEATH Month <u>March</u> Day <u>18</u> , Year <u>19 67.</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/1917</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Repair</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank Kowalski</u>						14. MOTHER'S MAIDEN NAME <u>Victoria ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>				16. SOCIAL SECURITY NO. <u>216-05-9072</u>		17. INFORMANT Address <u>Mrs. Elizabeth Kowalski, 1955 Walnut Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>1939</u> DUE TO <u>Cholelithiasis Muliplex gr III Tapped</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Non-removal of gall</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> , 19 <u>66</u> to <u>3-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-18-1967</u> and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles E Thompson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-18-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. CHARLES THOMPSON</u>						22d. ADDRESS <u>2903 W. WOODWELL ROAD, 21222, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE.</u>						25a. REC'D BY REGISTRAR <u>DATE 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03255

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY IN 1b <i>15 min</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Balto. Co. Gen. Hosp.</i>		d. STREET ADDRESS <i>7310 Dooman Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>CATHERINE MARIE KRAJEWSKI</i>		4. DATE OF DEATH Month <i>Mar</i> Day <i>8</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 28 '86</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) <i>80</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Poland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Regina Krajewski</i>		Address <i>7319 Elmwood</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple injuries</i> <i>8124</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>E Fractured Skull</i> (c) <i>due to</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Bashed over by car.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>8:44</i> <i>Mar 8 '67</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Driveway of home - Balto</i>		20f. (City or town) (County) (State) <i>Balto Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>3-8-167</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-11-1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cantius</i>		23d. LOCATION (City or Town) (County) (State) <i>Windber, Pennsylvania</i>	
24. FUNERAL DIRECTOR <i>Ellsworth Armacost</i>		25a. REC'D BY REGISTRAR <i>MAR 10 1967</i>	
ADDRESS <i>Ellsworth Armacost - 4600 Liberty Hghts. Ave.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03322

03322

IN THE COURT OF THE DISTRICT OF COLUMBIA

U.S. DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

U.S. DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03263

CERTIFICATE OF DEATH

03256

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 53yrl0mth15dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03.1 d. STREET ADDRESS Bay View Hospital e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Kral Last 4. DATE OF DEATH Month March Day 29 Year 19 67		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 5-23-88 9. AGE (In years lost birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrial worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Kral		14. MOTHER'S MAIDEN NAME Magdalene Snerha	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-3196-T 17. INFORMANT Address Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1979 IMMEDIATE CAUSE (a) Bronchopneumonia; organism unknown DUE TO (b) Pulmonary metastases DUE TO (c) Fibrosarcoma of the abdomen INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from 5-14-13 , 19 67 to March 29 67 , that (x) (we) last saw the deceased alive on March 29 , 19 67 , and that death occurred at 9:35 M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-29-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS For Corl Baker Inc. 1217 St. Paul St.		25a. REC'D BY REGISTRAR APR 4 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03257

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 1538 Oakridge Road	
3. NAME OF DECEASED (Type or print) First STEPHANIE Middle Page Last KRAMER		4. DATE OF DEATH Month March Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1940
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME W. Frank Just		14. MOTHER'S MAIDEN NAME Ethel V. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-38-4768	
17. INFORMANT Mr. Charles P. Kramer		Address same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8164 IMMEDIATE CAUSE (a) Craniocerebral Injury. DUE TO (b) — DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year 12:05 a.m. 3/ 11 1967		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. J. Turner & Sons		25a. REC'D BY REGISTRAR DATE MAR 20 1967	
25b. REGISTRAR'S SIGNATURE Charles S. Petty		22. DATE SIGNED 3/16/67	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03265

CERTIFICATE OF DEATH

03258

1. PLACE OF DEATH a. COUNTY BAITIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 127 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 3438 ERDMAN AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH P. KRASTEL		4. DATE OF DEATH Month Day Year MARCH 17 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/91
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER ROLLER MAN	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME PHILIP KRASTEL		14. MOTHER'S MAIDEN NAME IDA GORZUCH GOSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 18 36 25	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5401 GASTRIC PERFORATION, ACUTE DUE TO (b) CEREBRAL THROMBOSIS (c) LOBAR PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXX this hospital attended the deceased from 11/10/66 , 19__, to 3/17/67 , 19__, that (s) (we) last saw the deceased alive on 3/17/67 , 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/20/67	
23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME		25a. REC'D BY REGISTRAR 22 1967	
25b. REGISTRAR'S SIGNATURE James J. [Signature]		25c. DATE 3/20/67	

3331 Brehms Lane, Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03266				CERTIFICATE OF DEATH			03259			
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 6517 Alta Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ann KROCHESKI					4. DATE OF DEATH Month Day Year March 11, 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1933 September 1, 1932		9. AGE (In years last birthday) 33 24 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Dominic Gallo					14. MOTHER'S MAIDEN NAME Antoinette Konopka					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Bernard M. Krocheski				Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub arachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/27/ , 19 67 , to 3/11/ , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 3/11/ , 19 67 , and that death occurred at 7:34 AM , from causes and on the date stated above.										
22a. SIGNATURE <i>Pridipongse Vithespongse</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED March 11, 1967		
22c. PHYSICIAN'S NAME (Type) Pridipongse Vithespongse, M.D.					22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/67.		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE MAR 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 1509 LANCASTER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOSEPH Middle -- Last KULAK			4. DATE OF DEATH Month MARCH Day 13 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 3, 1896		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINE ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY SHIPPING		11. BIRTHPLACE (County & State, or foreign country) SHAMOKIN, PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ALEXANDER KULAK		
14. MOTHER'S MAIDEN NAME AMELIA MN: UNKNOWN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		
16. SOCIAL SECURITY NO. 212 18 55 50			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE AND CONGESTIVE DUE TO HEART FAILURE (c) ---					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY EMPHYSEMA					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 3/5/67 , 19__, to 3/13/67 , 19__, that he (we) last saw the deceased alive on 3/13/67 , 19__, and that death occurred at 2:30 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>Peter V. Juvan</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO FUNERAL	
25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>		DATE MAR 15 1967 257 S. CONKLING ST. BALTIMORE, MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03268		CERTIFICATE OF DEATH		03261	
1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204			d. STREET ADDRESS 9407 Fullerdale Ave. #21234		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) CHARLOTTE R. KYLE			4. DATE OF DEATH Month March Day 29 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-15	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Social Security Administration		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
13. FATHER'S NAME Sylvanus R Weaver			14. MOTHER'S MAIDEN NAME Lillian Schwemm		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-1169		17. INFORMANT Family Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra Cerebral Hemorrhage DUE TO Perry Aneurysm of the left posterior cerebral artery (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5-28- , 19 67 to 5-29-67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3-29- , 19 67 , and that death occurred at 4:00 p.m. from causes and on the date stated above.					
22a. SIGNATURE Lawrence T. Misanik			22b. DATE SIGNED 3-29-67		
22c. PHYSICIAN'S NAME (Type) Lawrence T. Misanik			22d. ADDRESS 7620 York Road, Baltimore, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md		
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road			25a. REC'D BY REGISTRAR MAR 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03269

CERTIFICATE OF DEATH

03262

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS Shore Acres	
3. NAME OF DECEASED (Type or print) ELIZABETH (BESSIE) LANG		4. DATE OF DEATH Month March , Day 16 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 83
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dwight Tuttle		14. MOTHER'S MAIDEN NAME Annie Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-30-1614 B	
17. INFORMANT Mr. John D. Lang, 13 Summitt Avenue 21228		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to 3-16-67 , 19 67 , that (I) (we) last saw the deceased alive on 3-16-67 , 19 67 , and that death occurred at 7:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE John Nesbitt		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) Dr. John Nesbitt		22d. ADDRESS 1009 Frederick Ave., Balto., Md. 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Swartz Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore City, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR MAR 20 1967	
		25b. REGISTRAR'S SIGNATURE John D. Lang	

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CERTIFICATE OF DEATH

03263

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4001 Chesley Avenue		d. STREET ADDRESS 4001 Chesley Avenue 6	
3. NAME OF DECEASED (Type or print) George Frederick Lehmann		4. DATE OF DEATH Month 3 Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	9. AGE (In years last birthday) 78 yrs.
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lehmann		14. MOTHER'S MAIDEN NAME Marie Blauman-Zukow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9058	
17. INFORMANT Mr Philip T. Thomas		Address 6709 Collinsdale Road 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease with congestive failure DUE TO (c) 34-3			INTERVAL BETWEEN ONSET AND DEATH 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1 , 19 62 , to Mar 23 , 19 62 , that (I) (we) last saw the deceased alive on Feb 1 , 19 62 , and that death occurred at March 24 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE Dr Rudolph H. Spitzberg		22b. DATE SIGNED March 24, 1967	
22c. PHYSICIAN'S NAME (Type) Dr Rudolph H. Spitzberg		22d. ADDRESS 338 W. Pratt Street Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-27-1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home		25. REG'D BY REGISTRAR Charles Judge	
20 M 1/66		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03271					03264				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6912 Golden Ring Road					d. STREET ADDRESS 343 Worton Road #21				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anna Mary Lengsfeld					4. DATE OF DEATH March 13, 1967				
5. SEX female					6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1906
9. AGE (In years last birthday) 60 yrs.					IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Julius B. Richter					14. MOTHER'S MAIDEN NAME Mary Leikuhler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 212-01-5175		17. INFORMANT Daughter Address Lillian M. Duke, 6912 Golden Ring Rd. #21				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1561 IMMEDIATE CAUSE (a) Cocaine of liver DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH 2 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 , to Mar 13, 1967 , that (I) (we) last saw the deceased alive on Mar 13, 1967 , and that death occurred at 11:45 P M, from causes and on the date stated above.									
22a. SIGNATURE Dr. Louis Seminoff					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/15/67		
22c. PHYSICIAN'S NAME (Type) Dr. Louis Seminoff					22d. ADDRESS 2108 Orems Road (Aero Acres)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13					25a. REC'D BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03272

CERTIFICATE OF DEATH

03265

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 819 S. HANOVER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BUDDIE		First Middle Last --- -- LESTER		4. DATE OF DEATH Month MARCH Day 26 Year 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1889		9. AGE (In years lost birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LAWRENCEVILLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DERMIS LESTER			14. MOTHER'S MAIDEN NAME DINAH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212 01 90 62		17. INFORMANT VA HOSPITAL			CLINICAL RECORDS FORT HOWARD, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, ACUTE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBROVASCULAR ARTERIOSCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 23 , 19 67 , to MARCH 26 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 26 , 19 67 , and that death occurred at 1254 M, from causes and on the date stated above.							
22a. SIGNATURE George Dudas				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF March 28, 1967		23c. NAME OF CEMETERY OR CREMATORY JONES CEMETERY		23d. LOCATION (City or Town) (County) (State) LAWRENCEVILLE, VIRGINIA	
24. FUNERAL DIRECTOR ORIS P. JONES				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

038373

038369

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item #2c&d Film #G387 4/6/67 pc

CERTIFICATE OF DEATH

Item #9 Film #G387 4/5/67 pc

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Presbyterian Home</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson Baltimore</u></p> <p>d. STREET ADDRESS <u>916 W. 38th St. Presbyterian Home</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Ida</u> Middle <u>L.</u> Last <u>Lilly</u></p>		<p>4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1967</u></p>	
<p>5. SEX <u>female</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Oct. 31, 1878</u></p>
<p>9. AGE (In years last birthday) <u>89</u> yrs.</p>	<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Maryland</u></p>
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>Robert Thomas Lilly</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>Sarah E. Phelps</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>h.</u></p>	
<p>17. INFORMANT Address <u>Presbyterian Home of Maryland</u></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> DUE TO (e), stating the underlying cause last. (c)</p> </div> </p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>ASCVD</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.</p>	<p>20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work</p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town) (County) (State)</p>
<p>21. I certify that (I) <u>doctor</u> attended the deceased from <u>Jan. 1958</u> to <u>March 27, 1967</u>, that (I) <u>no</u> saw the deceased alive on <u>March 27, 1967</u>, and that death occurred at <u>5 p.m.</u> from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>S. J. Venable, Jr. M.D.</u> M.D.</p>		<p>22b. DATE SIGNED <u>3-29-67</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u></p>		<p>22d. ADDRESS <u>7215 York Road, Baltimore, Md</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE THEREOF <u>3/30/67</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Franklinville Cem.</u></p>	<p>23d. LOCATION (City, town or county) (State) <u>Bradshaw, Maryland</u></p>
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Mitchell-Wiedefeld Home</u></p>		<p>25a. REC'D BY REGISTRAR <u>APR 3 1967</u></p>	
<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>		<p>25c. ADDRESS <u>Baltimore, Maryland 21212</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

BETTER BUSINESS FORMS, INC., BALTIMORE, MD. 21201

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03274

03267

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Reisterstown</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Saffell Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Reisterstown</u> 03-1 d. STREET ADDRESS <u>Saffell Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>FRANCES</u> First <u>THOMAS</u> Middle <u>LITTLE</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1967</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 26, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>17</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES POLK SINGLETON</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET NORRIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-54-7105</u>		17. INFORMANT (Daytime) <u>838-5028</u> Address <u>Mrs. Maud I. Amos</u> <u>1314 E. 3rd St., Baltimore, Maryland 21014</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocarditis - decompensated</u> (b) <u>4221 DUE TO Emphysema -</u> (c) <u>Chronic obstructive pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1967</u> to <u>3-17-1967</u>, that (I) (we) last saw the deceased alive on <u>3-17-1967</u>, and that death occurred at <u>1967</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>James G. Saffell MD</u>				22b. DATE SIGNED <u>3-17-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>				22d. ADDRESS <u>Reisterstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harf. Co., Md., 21014</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway & Williams</u> <u>Bel Air, Maryland 21014</u>				25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

08880

08880

MAR 11 1967

03275

CERTIFICATE OF DEATH

03268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY 30-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Randallstown			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home				d. STREET ADDRESS 3801 Roland Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lloyd Middle B. Last Loats				4. DATE OF DEATH Month March Day 13 Year 19 67			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1892		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Business		11. BIRTHPLACE (County & State, or foreign country) Manchester, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horatio Loats				14. MOTHER'S MAIDEN NAME Mary Baltozer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-8921A		17. INFORMANT Mrs. Evelyn Provenzano-7105 Manila Ave.		Address 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis, old & recent DUE TO atherosclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Sept 5, 1965 to March 13, 1967 , that (I) (we) last saw the deceased alive on March 2, 1967 , and that death occurred at 3:14-67 M, from causes and on the date stated above							
22a. SIGNATURE Dr. Rafael Perez-Mera				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-14-67	
22c. PHYSICIAN'S NAME (Type) Dr. Rafael Perez-Mera				22d. ADDRESS 7306 Liberty Rd. Balt., Md. 21207			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.				25. REGISTRY BY REGISTRAR MAR 16 1967		25. REGISTRAR'S SIGNATURE Charles Judge	

03320

RECEIVED

03320

UNCLASSIFIED
DATE 11/11/03 BY 60321 KOT/OC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03276

03269

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>2 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shirley Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>Rolland Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Edna Ray Lowe</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 67</u>		5. SEX <u>Female</u>									
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 10, 1886</u>									
9. AGE (In years last birthday) <u>81</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Office Work</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Lowe</u>									
14. MOTHER'S MAIDEN NAME <u>Alice Hann</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-2587-A</u>									
17. INFORMANT <u>Mrs. Tilly Bates Reisterstown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1532 Hepatic failure</u> DUE TO (b) <u>Hepatic metastasis</u> DUE TO (c) <u>Descending colon carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Philip Bernstein</u>				22b. DATE SIGNED <u>3/18/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>PHILIP BERNSTEIN</u>				22d. ADDRESS <u>112 CHARLEY DR REISTERSTOWN, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Greenmount, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Tipton - Eline Funeral Home Hampstead, Md.</u>											
25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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Figure 1. The effect of the concentration of the initiator on the polymerization of α -methylstyrene in the presence of C^{10}H_8 at 50°C .

total = 2011

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03277

CERTIFICATE OF DEATH

03270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b Halethorpe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1203 Oakland Terrace Road		d. STREET ADDRESS 1203 Oakland Terrace Road	
3. NAME OF DECEASED (Type or print) BERTHA A. Ludwig		4. DATE OF DEATH Month March Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Tuebner		14. MOTHER'S MAIDEN NAME Mary C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Roberta F. Braecklein, 1203 Oakland Rd.		Address Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Hypertensive cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 years 5 years 13 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 58 to Mar-12 , 1967, that (I) (we) last saw the deceased alive on Mar. 9 , 1967, and that death occurred at 2 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Louis E. Wice		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. Louis E. Wice		22d. ADDRESS 920 St. Paul Street Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-16-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25. REC'D BY REGISTRAR MAR 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03237

CERTIFICATE OF MARRIAGE

03237

State of

County of

City of

State of

County of

1900

1900

State of

State of

State of

State of

State of

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03278		03271	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u> c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Upper Falls Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u> d. STREET ADDRESS <u>Upper Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lund</u> Last <u>Lund</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 2, 1893</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bridge Constructor</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Denver Colorado</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>173-01-9326</u> 17. INFORMANT <u>Lillian Lund</u> Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Perforated Esophagus - Adhesions</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>64</u> , to <u>March 26</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>Feb 27</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E Bush MD</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>3/26/67</u> 22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grave Run Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hampstead, R.D. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Male white
 Charles X
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 Hampton Road
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Oak County
 County Clerk
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03279

CERTIFICATE OF DEATH

04446

Items #11 & 12 Film #G300 3/16/67 pc

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Conv. Home 301 West Chesapeake Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 501 West University Parkway	
3. NAME OF DECEASED (Type or print) First Rufus Middle Charles Last Mac Lellan		4. DATE OF DEATH Month March Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1881
9. AGE (In years last birthday) 86 yrs.		10. BIRTHPLACE (County & State, or foreign country) Maryland	11. CITIZEN OF WHAT COUNTRY? U.S.A.
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ad Manager		13. FATHER'S NAME Arthur R. MacLellan	
14. MOTHER'S MAIDEN NAME Louisa J. Talbot		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Arthur MacLellan same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Acute Cardiac Failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/10/1967 to 3/9/67, that (I) (we) last saw the deceased alive on 3/9/67, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 York Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/11/1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn, Maryland Woodlawn Cemetery	23d. LOCATION (City, town or county) Baltimore 21212 Md
24 FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tichner & Sons		25a. REC'D BY REGISTRAR Charles Judge	

03213

CENTRAL DE OCEANO

Form with multiple sections and fields, including a large table area. The text is mirrored and difficult to read, but appears to be a technical or administrative document. The form includes various headings, sub-headings, and a large table with multiple columns and rows. The text is oriented vertically on the page.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03280

CERTIFICATE OF DEATH

03272

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville	
c. LENGTH OF STAY IN Tb 10 years		d. STREET ADDRESS -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle MALATT Last MALATT		4. DATE OF DEATH Month 3 Day 13 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-10
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 3 Days 13 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Malatt (Dec.)		14. MOTHER'S MAIDEN NAME Effie Katherine Kelly (Dec.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Necrotizing Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Institutionalization due to residual of poliomyelitis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 56 , to 3-13 , 19 67 , that (I) (we) last saw the deceased alive on 3-13 , 19 67 , and that death occurred at 2:00 P.M. on 3-13 , 19 67 , and that death was caused by the causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 14 Mar 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY Rosewood		23d. LOCATION (City or Town) (County) (State) Owings Mills Md	
24. FUNERAL DIRECTOR J F Eline & Sons Tristerstown Md		25a. REC'D BY REGISTRAR MAR 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03815

STATE OF NEW YORK

03815

State of New York

Department of Health

Robert A. Jones

James A. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03281						CERTIFICATE OF DEATH						03273	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						d. STREET ADDRESS 345 S. FURROW STREET						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle C Last MARTIN						4. DATE OF DEATH Month MARCH Day 1 Year 19 67							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH AUGUST 30, 1886		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MINERAL COUNTY, W. VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN B. MARTIN						14. MOTHER'S MAIDEN NAME MARTHA							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I				16. SOCIAL SECURITY NO. 220 07 65 92		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF LEFT LUNG 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) LAENNEC'S CIRRHOSIS DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from MARCH 1 , 19 67 to MARCH 1 , 19 67 , that (I) (we) last saw the deceased alive on MARCH 1 , 19 67 , and that death occurred at 1120P , from causes and on the date stated above.													
22a. SIGNATURE <i>Peter V. Jovan</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/2/67					
22c. PHYSICIAN'S NAME (Type) PETER V. JOVAN, M. D.						22d. ADDRESS VAH FT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/6/67		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>						ADDRESS JOSEPH N. ZANNINO FUNERAL HOME		25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>			
						257 S. CONKLING ST. BALTIMORE, MD.							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03274

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 601 Cranbrook Road	
3. NAME OF DECEASED (Type or print) Samuel Ralph Mason		4. DATE OF DEATH Month March		Day 11	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 17, 1904		9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 11	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Edward Mason	
14. MOTHER'S MAIDEN NAME Mary Rau		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-10-5081	
17. INFORMANT Mrs. Jennie S. Mason		Address 601 Cranbrook Rd 21030		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3/11/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/14/67		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	
23d. LOCATION (City or Town) Baltimore, Maryland		23e. REGISTRAR'S SIGNATURE Charles Judge		23f. REC'D BY REGISTRAR MAR 14 1967	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204					

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MAR 14 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03283					03275							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY Baltimore					a. STATE Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY —							
c. LENGTH OF STAY IN 1b 3yr3mth26dys					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 1802 Morrell Park Avenue							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		Month		Day		Year			
First Middle Last Victoria Frances Matalis			March 13 19 67									
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.					
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Dec. 24, 1888	78 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress			10b. KIND OF BUSINESS OR INDUSTRY Chalkley Co.		11. BIRTHPLACE (County & State, or foreign country) Lithuania			12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Frank Vabalas					14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 215-01-5393		17. INFORMANT Records:			Address SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain dis.											INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)			(County)		(State)							
21. I certify that (if) (this hospital) attended the deceased from Nov. 17 19 63 to March 13 19 67 , that (if) (we) last saw the deceased alive on March 13 19 67 , and that death occurred at 6:25 M, from the causes and on the date stated above.												
22a. SIGNATURE Evelio A. Felipe, M.D.			22b. DATE SIGNED 3-14-67			22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Con.			23d. LOCATION (City, town or county) (State) 4430 Holman Rd. Md.				
24. FUNERAL DIRECTOR John J. Connerdon			ADDRESS 32 Hollins			25a. REC'D BY REGISTRAR 15 1967			25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03276

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. General Hospital				d. STREET ADDRESS 5414 Gwynndale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur		First B.		Last Maton		4. DATE OF DEATH Month Mar.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1890	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Balto. City Water Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Maton				14. MOTHER'S MAIDEN NAME Elizabeth Dorsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-12-0593		17. INFORMANT Mrs. Glenda Maton, 5414 Gwynndale Ave.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples		M.D. D. D. Caples, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-14-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd., Baltimore, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address, (Street, City, Town, & County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/67		23c. NAME OF CEMETERY OR CREMATORY Western		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR John T. Stansbury				ADDRESS 6411 Windsor Mill Rd.		25a. REC'D BY REGISTRAR MAR 16 1967	
				25b. MEDICINE DEPARTMENT SIGNATURE [Signature]			

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00324

[Faint, mostly illegible text covering the page, possibly a document or report. The text is mirrored and appears to be bleed-through from the reverse side of the paper.]

CERTIFICATE OF DEATH

03277

03285

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 53yr10mth12dys Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Bay View Hospital	
3. NAME OF DECEASED (Type or print) First Samuel Middle Maxwell Last Maxwell		4. DATE OF DEATH Month March Day 26 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel t. Maxwell	
14. MOTHER'S MAIDEN NAME Emma ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-54-3228 J1		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic cardiovascular Heart Dis DUE TO (c) Arteriosclerosis, generalized, senile		INTERVAL BETWEEN ONSET AND DEATH acute 20yr. 25yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 14, 1913 to March 26, 1967 , that (I) (we) last saw the deceased alive on March 26, 1967 , and that death occurred at 8:00 p.m. , from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

77860

48360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03286

CERTIFICATE OF DEATH

03278

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>60 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>911 Glenwood Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>911 Glenwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Percy B. McAlpin</u> First Middle (McAlpin) Last		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Worker</u>	9. AGE (In years last birthday) yrs. <u>71</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>McAlpin</u>		14. MOTHER'S MAIDEN NAME <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-32-6347</u>	
17. INFORMANT <u>Mrs. Cassie McAlpin</u>		Address <u>911 Glenwood Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspirin</u> DUE TO (b) <u>Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Mar</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 3</u> , 19 <u>67</u> , and that death occurred at <u>A.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>R J Lyden</u>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Lyden, M.D.</u>		22d. ADDRESS <u>6402 Golden Ring Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Leo & Cook</u>		25a. REC'D BY REGISTRAR <u>7208 Hayford Road</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		DATE <u>MAR 27 1967</u>	

03378

EXHIBIT OF DEATH

03380

6002 Golden Ring Road

Robert J. Lyden, M.D.

03287

CERTIFICATE OF DEATH

03279

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, Md.		c. LENGTH OF STAY IN lb 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2516 Lawnside Rd.		d. STREET ADDRESS 2516 Lawnside Rd.	
3. NAME OF DECEASED (Type or print) Thomas J. McMahon		4. DATE OF DEATH Month 3 , Day 26 , Year 1967	
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1919
9. AGE (In years lost birthday) yrs. 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. Western Electric	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. McMahon		14. MOTHER'S MAIDEN NAME Mary Delaney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. WWII		16. SOCIAL SECURITY NO. 131 07 0243	
17. INFORMANT Catherine M. McMahon, Timonium, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Myocardial Infarction DUE TO (c) ASCD	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/66 , 19 to 3/26 , 1967, that (I) (we) last saw the deceased alive on 3/26 , 1967, and that death occurred at 1:34 M, from causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT J. MAHON		22d. ADDRESS 204 E JOPPA RD TOWSON 4 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR DATE MAR 30 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

03288

03280

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7228 Stratton Way # 21224</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u> d. STREET ADDRESS <u>7228 Stratton Way #21224</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GILBERT</u> 5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1903</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u>63</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u>16</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coil Stocker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steell Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			
13. FATHER'S NAME <u>Wilbur G. Michael</u>		14. MOTHER'S MAIDEN NAME <u>Frances Varina</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-6090</u>		17. INFORMANT <u>Victoria E. Michael</u> Address <u>Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 443X DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/59</u> , 19 <u>59</u> , to <u>3/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2/67</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Max Baum</u> 22c. PHYSICIAN'S NAME (Type) <u>Max Baum</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7422 Eastern Blvd., Balto., 21204, Md.</u>		22b. DATE SIGNED <u>3/17/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-20-67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zeiler</u>		ADDRESS <u>6224 Eastern Ave. Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03289

CERTIFICATE OF DEATH

03281

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 51 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 4700 Haldane Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KENNETH A. MITCHELL		4. DATE OF DEATH Month Day Year MARCH 6 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/94
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY WOOD	
11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. MITCHELL		14. MOTHER'S MAIDEN NAME LAURA (KOONARD) Coonrod	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214 03 72 12	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTENSIVE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EDEMA DUE TO (c) 4201		INTERVAL BETWEEN ONSET AND DEATH OLD & RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) BENIGN PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/14/67 , 19__, to 3/6/67 , 19__, that (X) (we) lost the deceased alive on 3/6/67 , 19__, and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Howard C. Kramer</i>		22b. DATE SIGNED 3/7/67	
22c. PHYSICIAN'S NAME (Type) HOWARD C. KRAMER, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-9-67	
23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR RUCK FUNERAL HOME		25. REGISTRY DATE MAR 9 1967	
26. REGISTRY SIGNATURE <i>Howard C. Kramer</i>		27. REGISTRY SIGNATURE <i>Howard C. Kramer</i>	
28. ADDRESS 5305 HARFORD ROAD, BALTIMORE, MD.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03290					03282				
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Q. Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadenca d. STREET ADDRESS 43 Stone Drive e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs. Mary Ellen Mitchell		First Ellen		Middle Mitchell		Last Mitchell		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX F.		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/97		9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Chalk					14. MOTHER'S MAIOEN NAME More Gill				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-03-6314		17. INFORMANT Records, Mount Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive pulmonary emphysema 5271 DUE TO (b) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 4, 1967 to March 22, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 34 M. from the causes and on the date stated above.									
22a. SIGNATURE W. Newcomer								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent								22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cem		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225						25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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03291

CERTIFICATE OF DEATH

03283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30-4</u> <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROSEWOOD STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TERRY</u> Middle <u>MONROE</u> Last <u>MONROE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>10</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAWRENCE TERRY MONROE</u>		14. MOTHER'S MAIDEN NAME <u>LORETTA LOUISE PINKNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bilateral bronchopneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>3/18/67</u> , 19 <u>67</u> , and that death occurred at <u>4:00</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD.</u>
24. FUNERAL DIRECTOR <u>JOSEPH KNIGHT-F. HOME 1639 N. BROADWAY</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

03333

CERTIFICATE OF DEATH

03333

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03292					03284				
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>— ? —</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. JOSEPH'S HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON 4, MARYLAND</u> d. STREET ADDRESS <u>608 STEVENSON LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>JANET</u> Middle <u>E. T.</u> Last <u>MONTGOMERY</u>			4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1967</u>						
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1891</u>	9. AGE (in years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTERED NURSE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>BRITAIN</u>		
13. FATHER'S NAME <u>JAMES C. MONTGOMERY</u>			14. MOTHER'S MAIDEN NAME <u>VIOLET MONTGOMERY</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>217-B-6228</u>		17. INFORMANT Address <u>Mrs. J. C. Campbell (sister) 608 Stevenson Lane</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertensive Arteriosclerotic C.V. Disease</u> b) <u>—</u> c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>3 March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3 March</u> 19 <u>67</u> , and that death occurred at <u>8:30 p.m.</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Francis L. Brown M.D.</u>					22b. DATE SIGNED <u>3 March 67</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <u>431 East Lake Ave 21212</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>Mar-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GreenMount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore-21202</u>		
24. FUNERAL DIRECTOR <u>Stewart & Mowen Co. 108-W-North-Av-21201</u>					25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

03332

03334

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Richard H. H. H.

Hyattsville, D.C.

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James L. H. H.

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Released by Dr. Spitz - M.E. Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation or removal and in any event within 72 hours after death.

FULL NAME OF DECEASED
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03285

1. NAME OF DECEASED (Type or Print) 940 Thompson Blvd.		2. DATE AND HOUR OF DEATH 6:30 AM 3/7/67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Name of deceased: LEONARD MOROZ, JR. FULL NAME OF HOSPITAL OR INSTITUTION COUNTY: BALTIMORE Baltimore - 21 940 Thompson Blvd.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md D. STREET ADDRESS (If rural, give location) 940 Thompson Blvd	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED, DIVORCED (specify) Child	8. DATE OF BIRTH Aug 26, 1965
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonard R. Moroz SR		14. MOTHER'S MAIDEN NAME Marina Eckert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Father		ADDRESS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES 2892 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Failure to Throie (B) DUE TO Possible Metabolic Disorder. (C) —	
19. TIME OF INJURY (APPROX.) 3		20. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from February 15, 1967 to February 23, 1967 that (I) (we) last saw the deceased alive on February 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		22. DATE SIGNED 3/7/67	
23A. SIGNATURE A. Baghdassarian		23B. DATE SIGNED 3/7/67	
23C. PHYSICIAN'S NAME (Type) A. BAGHDASSARIAN		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/9/67	
24C. NAME OF CEMETERY or CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967		25B. NAME OF REGISTRAR Johnas Judge	
25C. FUNERAL DIRECTOR J.G. CONNELLY		ADDRESS 300 MACE	

03282

OFFICE OF DEATH

03282

1. NAME OF DECEASED (Last, First, Middle Initial)

DATE OF BIRTH

DATE OF DEATH

STATE OF TEXAS

COUNTY OF

2. PLACE OF BIRTH (City, State, Country)

3. PLACE OF DEATH (City, State, Country)

4. OCCASION OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)

5. CAUSE OF DEATH (Disease, Injury, Poison, etc.)

6. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)

7. TIME OF DEATH (Hour, Minute, Second)

8. PLACE OF INTERMENT (City, State, Country)

9. NAME OF FUNERAL HOME (City, State, Country)

10. NAME OF MINISTER (City, State, Country)

11. NAME OF CLERGYMAN (City, State, Country)

12. NAME OF CHURCH (City, State, Country)

13. NAME OF CEMETERY (City, State, Country)

14. NAME OF BURIAL (City, State, Country)

15. NAME OF CREMATION (City, State, Country)

16. NAME OF URN (City, State, Country)

17. NAME OF CASK (City, State, Country)

18. NAME OF COFFIN (City, State, Country)

19. NAME OF CASKET (City, State, Country)

20. NAME OF CASKET (City, State, Country)

21. NAME OF CASKET (City, State, Country)

22. NAME OF CASKET (City, State, Country)

23. NAME OF CASKET (City, State, Country)

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42. NAME OF CASKET (City, State, Country)

1. NAME OF DECEASED (Last, First, Middle Initial)

2. PLACE OF BIRTH (City, State, Country)

3. PLACE OF DEATH (City, State, Country)

4. OCCASION OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)

5. CAUSE OF DEATH (Disease, Injury, Poison, etc.)

6. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)

7. TIME OF DEATH (Hour, Minute, Second)

8. PLACE OF INTERMENT (City, State, Country)

9. NAME OF FUNERAL HOME (City, State, Country)

10. NAME OF MINISTER (City, State, Country)

11. NAME OF CLERGYMAN (City, State, Country)

12. NAME OF CHURCH (City, State, Country)

13. NAME OF CEMETERY (City, State, Country)

14. NAME OF BURIAL (City, State, Country)

15. NAME OF CREMATION (City, State, Country)

16. NAME OF URN (City, State, Country)

17. NAME OF CASK (City, State, Country)

18. NAME OF COFFIN (City, State, Country)

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38. NAME OF CASKET (City, State, Country)

39. NAME OF CASKET (City, State, Country)

40. NAME OF CASKET (City, State, Country)

41. NAME OF CASKET (City, State, Country)

42. NAME OF CASKET (City, State, Country)

03294

CERTIFICATE OF DEATH

03286

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 4740 Shyamrock Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Mary Morris		4. DATE OF DEATH Month Day Year March 29, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-20
9. AGE (In years last birthday) yrs. 47		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard E. Loewer		14. MOTHER'S MAIDEN NAME Katherine Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Morris, husband, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, metastatic of lung and brain DUE TO secondary to carcinoma of breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 12, 19 67 , to March 29, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 29, 19 67 , and that death occurred at 6:00AM , from causes and on the date stated above.			
22a. SIGNATURE <i>J. Ambrad</i>		22b. DATE SIGNED March 29, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03232

RECEIVED BY DEATH

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03295

CERTIFICATE OF DEATH

03287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS Box 38	
3. NAME OF DECEASED (Type or print) First Barbara Middle Joan Last MOZINGO		4. DATE OF DEATH Month March Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-64
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ronald Edward Mazingo		14. MOTHER'S MAIDEN NAME Delores Joan Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO (b) Respiratory difficulty DUE TO (c) Prob. aspiration pneumonia			
INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Microcephalic blind, deaf, severe mental retardation			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 6-9 , 19 66 , to 3-3 , 19 67 , that (I) (X) saw the deceased alive on 3-3 , 19 67 , and that death occurred at 9:00 P M, from causes and on the date stated above.			
22a. SIGNATURE Barbara W. Hudson		22b. DATE SIGNED 3-3-67	
22c. PHYSICIAN'S NAME (Type) Rosewood State Hospital		22d. ADDRESS Rosewood State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.	
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 7 1967	

03282

RECORDS OF DEATH

03282

Proportion of deaths
attributable to different
causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

Proportion of deaths attributable to different causes of death

FOR STATE
HEALTH DEPT.

03296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03288

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital		d. STREET ADDRESS 1400 Bowles Terrace	
3. NAME OF DECEASED (Type or print) PAUL A. MULLIN		4. DATE OF DEATH Month March Day 19 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1934
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 12 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sr. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Martin Co.	
11. BIRTHPLACE (State or foreign country) East Lansdowne, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Mullin		14. MOTHER'S MAIDEN NAME Evalyn Craft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) Korean		16. SOCIAL SECURITY NO. 209-26-0342	
17. INFORMANT Mrs. Anne E. Mullin		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral contusions and subdural hemorrhage DUE TO (c) 816.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver in auto-truck collision			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-truck collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:03 1 20 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Baltimore Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 3/20/67	
EXAMINER'S NAME (Type) Charles S. Petty		M.D. Charles S. Petty DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/22/1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR MAR 21 1967	
4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0286

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03297

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03289

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle RICHARD Last MURPHY		4. DATE OF DEATH Month 3 Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/91
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Phillip A. Murphy	
14. MOTHER'S MAIDEN NAME Carrie P. Fish		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-12-6307A		17. INFORMANT Donald R. Murphy-412 Hillen Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Arteriosclerotic Cardio Renal DUE TO Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X		INTERVAL BETWEEN ONSET AND DEATH Sudden 5+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		22. DATE SIGNED 3/11/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 3/13/67	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd.		25. REC'D BY REGISTRAR MAR 14 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

03237

03237

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

No

213-12-03237

Bellevue

Bellevue

Bellevue

Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

03298

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03290

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d. STREET ADDRESS 3333 Gwynns Falls Parkway			
3. NAME OF DECEASED (Type or print) JOSEPH First MMN Middle NAVIASKY Last				4. DATE OF DEATH 3 Month 9 Day 19 Year 67			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-15-1900	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7		IF UNDER 24 HRS. Hours 1 Min. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER.				10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (County & State, or foreign country) BALTO, MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME NATHAN NAVIASKY				14. MOTHER'S MAIDEN NAME HILLMAN, Jennie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 219-12-8874		17. INFORMATION Chart Address High Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF LUNG DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-15-1967 , to 3-9-1967 , that (I) (we) last saw the deceased alive on 3-9-1967 , and that death occurred at 6:52 AM , from the causes and on the date stated above.							
22a. SIGNATURE Rann K. Chittler				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS GREATER BALTO. MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/10/67		23c. NAME OF CEMETERY OR CREMATORY Beth Eliah Cong		23d. LOCATION (City, town or county) (State) Balto, Md	
24. FUNERAL DIRECTOR Sol Lewinson - Person				ADDRESS 6010 Pershing Rd.		25a. REC'D BY REGISTRAR 13 DATE 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

03250

03250

15-17-51 2-8-51

James K. Christian

10/11/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03299					03291				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 28yr5mth14dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1110 Washington Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary Josephine Noone		4. DATE OF DEATH Month March Day 31 Year 19 67							
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1893	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS. Hours 1 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTH PLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John Noone				14. MOTHER'S MAIDEN NAME Sarah Callahan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 219-54-3258T		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, moderate, with psychotic reaction								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Oct. 17, 1938 , to March 31, 1967 , that (I) we last saw the deceased alive on March 31, 1967 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Evelio A. Felipe, M.D.				22b. DATE SIGNED 3-31-67					
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Balto Md			
24. FUNERAL DIRECTOR John J. Cowan				ADDRESS 901 J. Hollenbeck		25a. REC'D BY REGISTRAR APR 4 1967		25b. REGISTRAR'S SIGNATURE J. Charles	

03231

03232

WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03300

CERTIFICATE OF DEATH

03292

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisters town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>1404 Wheaton Lane</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>NORRIS</u> Middle Last		4. DATE OF DEATH <u>March 30</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1888</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Robert Norris</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Martha Norris</u> Address <u>item #2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bernstein</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton Montg Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25. APR 5 1967	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

03300

03300

03300

03300

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03301

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03293

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN TB 21227		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5707 First Avenue -				d. STREET ADDRESS 5707 First Avenue		21227	
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD JOHN NORRIS				4. DATE OF DEATH Month Day Year 3 14 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-1946		9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Norris				14. MOTHER'S MAIDEN NAME Florence D. Gillingham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-42-6678		17. INFORMANT Address Mr. James A. Norris, 5707 First Ave. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 4222 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-18-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03302

03294

Item #8 Film #G386 3/20/67 pg

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ruxton		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1811 Roland Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Bridgeport c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85-3 d. STREET ADDRESS Stout Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maude Middle M. Last Nuzum		4. DATE OF DEATH Month March Day 15, Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1874		9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19	
11. IF UNDER 24 HRS. Hours 15 Min. 93		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harlow Wilkinson		14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. George Bowles 1811 Roland Ave. Ruxton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) myocardial Failure DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 weeks					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bridgeport		20g. (County) W. Va.		20h. (State) MD	
21. I certify that (I) (this hospital) attended the deceased from Feb. 15, 1967 to March 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 1967 , and that death occurred at 9 P.M. from the causes and on the date stated above.					
22a. SIGNATURE George T. Gilmore		22b. DATE SIGNED March 15, 1967		22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE	
22d. ADDRESS YORK RD, LUTHERVILLE, MD		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/16/1967		23c. NAME OF CEMETERY OR CREMATORY Bendeum Cemetery	
23d. LOCATION (City, town or county) Bridgeport, W. Va.		23e. (State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fubner & Sons		24a. ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR MAR 17 1967	
24b. DATE 3/16/67		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1011 Street Ave.
London, England

Mr. George Brown

Mr. George Brown

London, England

Mr. George Brown

London, England

MAR 1 1961

Mr. George Brown

London, England

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03303

CERTIFICATE OF DEATH

03295

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 58 St. Joseph Hospital		d. STREET ADDRESS 3042 Woodside Avenue	
3. NAME OF DECEASED (Type or print) First Margaret Middle E. Last O'Connell		4. DATE OF DEATH Month March Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1895
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hospital	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. O'Connell		14. MOTHER'S MAIDEN NAME Margaret Thornton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-2047	
17. INFORMANT Mrs. Irene Duda		Address 3042 Woodside Avenue-21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-operative Hiatal Hernia 3-16-67		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 12, 1967 to March 24, 1967 , that (I) (we) last saw the deceased alive on March 24, 1967 and that death occurred at 4:00 M, from causes and on the date stated above.			
22a. SIGNATURE Antonio Razo		22b. DATE SIGNED March 24, 1967	
22c. PHYSICIAN'S NAME (Type) Antonio Razo M.D.		22d. ADDRESS 7620 York Road, Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-67	
23c. NAME OF CEMETERY OR CREMATORY Saint Peter's Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John C. Miller Inc-415 Belair Road-21206		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

03296

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.				c. LENGTH OF STAY IN 1b 43 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.				d. STREET ADDRESS 6514 Mt. Vernon Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6514 Mt. Vernon Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence V. Oler				4. DATE OF DEATH March 4, 1967			
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/1896	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sprinkle				14. MOTHER'S MAIDEN NAME Grace Ward			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Virginia M. Dillon				Address 21215 6514 Mt. Vernon Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cordeio-vascular Disease DUE TO (c) Complication of being with melanoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis with cholelithiasis + Calc of liver							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from meq , 19 66 , to 3/4 , 19 67 , that (I) (we) las saw the deceased alive on 3/4 19 67 , and that death occurred at 3:30 PM , from causes and on the date stated above			
22a. SIGNATURE Grace E. Jones, M.D.				22b. DATE SIGNED 3/7/67		22c. PHYSICIAN'S NAME (Type) Dr. Grace Jones	
22d. ADDRESS Walker Ave. Pikesville, Md. 21208				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 3/7/67				23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.				25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

03297

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton.</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		d. STREET ADDRESS <u>Hereford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hereford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>P. W. ADE</u> First Middle Last <u>PALMER</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5, 1905</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weighmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herbert Calvin Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Emma H. Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-1001</u>	
17. INFORMANT <u>Mrs. E. Madeline Palmer</u>		Address <u>Monkton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>177X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>MAR. 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAR 7</u> , 19 <u>67</u> , and that death occurred at <u>6:15</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Meth. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>White Hall R.D. Md.</u>
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom Pa.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPT. OF STATE

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03306

CERTIFICATE OF DEATH

03298

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 11 McCormick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell James Palmer		4. DATE OF DEATH Month March Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	11. BIRTHPLACE (County & State, or foreign country) Uniontown, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Palmer	
14. MOTHER'S MAIDEN NAME Ada Willett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 215-09-3907A		17. INFORMANT Anna Palmer 11 McCormick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 4, 1967 , to March 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 1967 , and that death occurred at 2:00AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Jaime Ambrad</i>		22b. DATE SIGNED March 15, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad		22d. ADDRESS 7620 York Road- Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION (City or Town) (County) (State) 4400 BELAIR RD MD
24. FUNERAL DIRECTOR DIPPEL BRAS INC		25a. REC'D BY REGISTRAR MAR 17 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>03307</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>Item #9 per teleph. conv. Lickhart E.L. 3/29/67 pc</p> </div> <div> <p>03299</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>Rt 2 Box 404 Sherwood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Iva</u> Middle <u>Elizabeth</u> Last <u>Parker</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-01</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (County & State, or foreign country) <u>Frederick County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Boosler Moser</u>				14. MOTHER'S MAIDEN NAME <u>Short</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-09-4165</u>		17. INFORMANT <u>A. Frank Parker</u>		Address <u>Owings Mills, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercurrent respiratory infection</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent carcinoma ovary, ascites, bone marrow depression</u> DUE TO (c) <u>Carcinoma of ovary</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13th</u> 19 <u>67</u> , to <u>March 22</u> , 1967, that (I) (we) last saw the deceased alive on <u>March 22th</u> 19 <u>67</u> , and that death occurred at <u>10⁴⁰</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Doherty</u>								M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dora C Kuwilsky</u>				22d. ADDRESS <u>Greater Baltimore Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>March 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Flint's Lurg Maryland</u>					
24. FUNERAL DIRECTOR <u>H.J. Eichardt</u>				ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

Baroness, Mrs. Evelyn Mary Gordon Fickelburg, Highland
MAR 27 1967

Don C. Evans, Jr.

Stamford

March 22, 67

For 12K of March 22, 67

✓ 8-22-67

Don C. Evans, Jr.

Continuation of copy

Resident residence copy, serial, and notes

Information requested

200-112 A Frank Parker Coward Mills, Md

Don C. Evans, Jr.

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Don C. Evans, Jr.

Townson
6 weeks
Coward Mills

03307

03307

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03308

CERTIFICATE OF DEATH

03300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holly Hill Manor		d. STREET ADDRESS 5515 Sefton Ave.	
3. NAME OF DECEASED (Type or print) First Sarah Middle A. Last Parker		4. DATE OF DEATH Month 3 Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1891
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months 1 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry vonGerlach		14. MOTHER'S MAIDEN NAME Anna Plummer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ann L. Streett, 503 Fairway Ct. #4		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Arteriosclerosis DUE TO (c) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 2 , 19 67 , to March 11 , 19 67 , that (I) (we) lost the deceased alive on March 11 , 19 67 , and that death occurred at 8:45 PM , from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Laurence E. Post		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) LAURENCE E. POST		22d. ADDRESS 8805 York Rd - Baltimore 21212 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.		25a. REC'D BY REGISTRAR DATE MAR 14 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03309

CERTIFICATE OF DEATH

03301

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>16 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>309 Alabama Road</u>		d. STREET ADDRESS <u>309 Alabama Road</u>	
3. NAME OF DECEASED (Type or print) <u>Robert S. Parr</u>		4. DATE OF DEATH <u>March 21 1967</u>	
5. SEX <u>male</u>		6. COLOR OF SKIN <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 January 1883</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coffee</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT S. PARR</u>		14. MOTHER'S MAIDEN NAME <u>BELLE Bibb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>wife</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>March 16 1967</u>		20f. (City or town) (County) (State) <u>March 16 1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 16 1967</u> to <u>March 21 1967</u> , that (I) (we) last saw the deceased alive on <u>March 16 1967</u> and that death occurred at <u>5A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter T. Kees</u>		22b. DATE SIGNED <u>21 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		22d. ADDRESS <u>Cockeyville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-24-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

103301

STATE OF TEXAS

103301

County of Tarrant
State of Texas
I, the undersigned, Clerk of the County of Tarrant, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

Witness my hand and the seal of said County at Fort Worth, Texas, this 1st day of January, 1901.

Clerk of County

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural Baltimore 21</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural Baltimore 21</i>				d. STREET ADDRESS <i>16 A. Westway South</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>16 A. Westway South</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Elizabeth A. Plarr</i>			First Middle Last			4. DATE OF DEATH <i>March 16, 19 67</i>			Month Day Year		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/31/1896</i>		9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dentist Office</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Spealman</i>						14. MOTHER'S MAIDEN NAME <i>Mary Bohs</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-32-2709 A</i>		17. INFORMANT <i>Agnes Morlock 16 A. Westway South</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Hypertensive Cardiovascular disease 78 yrs</i>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				22d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Theo C Patterson</i>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>3/17/67</i>		
EXAMINER'S NAME (Type) <i>THEO. C PATTERSON</i>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>3/18/1967</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
23. FUNERAL DIRECTOR <i>John A. Moran Inc. 3000 E. Baltimore St.</i>						ADDRESS		24a. REC'D BY REGISTRAR <i>Charles Judge</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAR 21 1967</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03311				CERTIFICATE OF DEATH				03303			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						d. STREET ADDRESS 5 West Chesley Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice G Phelps						4. DATE OF DEATH Month Day Year March 4, 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1890		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Kohlhafer						14. MOTHER'S MAIDEN NAME Annie Kahl					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-14-3321		17. INFORMANT Address Mrs Carrie Tayman 7522 Kenlea Avenue 36					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute generalized peritonitis 5401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) perforated gastric ulcer DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (A) (this hospital) attended the deceased from February 21, 1967 , to March 4, 1967 , that we (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 8:40 a.m. , from causes and on the date stated above.											
22a. SIGNATURE Lawrence F. Misanik								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 4, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D.						22d. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-7-1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Lorraine Funeral Home				ADDRESS 7401 Belair Road		25. DEED BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

03903

DEPARTMENT OF HEALTH

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03312

03304

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 68 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 2920 WINDSOR AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LESTER Middle FRANKLIN Last PIERSON				4. DATE OF DEATH Month MARCH Day 5 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 9, 1920		9. AGE (In years last birthday) yrs. 46		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOV'T		11. BIRTHPLACE (County & State, or foreign country) HOWARD COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY F. PIERSON				14. MOTHER'S MAIDEN NAME LEATHA JACKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212 16 08 47		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE MASSIVE DUE TO (b) CARCINOMA, FLOOR OF MOUTH DUE TO (c) ASPIRATION PNEUMONIA							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 27 , 19 66 , to MARCH 5 , 19 67 that <input checked="" type="checkbox"/> (we) lost the deceased alive on MARCH 5 , 19 67 , and that death occurred at 125A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR William C. March Funeral Home				25a. REC'D BY REGISTRAR DATE MAR 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

25a. REC'D BY REGISTRAR
DATE **MAR 8 1967**
25b. REGISTRAR'S SIGNATURE
Charles J. J...

03304

03318

MARYLAND

SEATTLE

BATINER

28 DAYS

PORT HOWARD

1920 WILSON AVENUE

WILSON ADMINISTRATION HOSPITAL

HARPER

PIERSON

TRANSMISSION

TESTER

AUGUST 2, 1920

MALE

U.S.A.

HOWARD COUNTY, MD.

LEWIS J. JACKSON

HARRY P. PIERSON

VA HOSPITAL

212 15 00 17 CLINICAL RECORDS - PORT HOWARD, MARYLAND

NO 11

YES

EXPERIMENTAL INVASIVE

CALCULUS, PLOD OF MOUTH

EXPERIMENTAL INVASIVE

60 MARCH 2 1920

NO. 11

MARCH 2, 1920

VAR PORT HOWARD, MARYLAND

MILSON DISORDER, . 11

WILSON ADMINISTRATION HOSPITAL

WILSON ADMINISTRATION HOSPITAL

WILSON C. PIERSON HOSPITAL

WILSON C. PIERSON HOSPITAL

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03313					03305				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 Milgate Road</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>15 Milgate Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>EDNA</u> <u>MAE</u> <u>POE</u>			First Middle Last		4. DATE OF DEATH <u>March</u> <u>18</u> , 19 <u>67</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1929</u>		9. AGE (In years last birthday) <u>37</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Owings Mills, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Charles Edward Whitcomb</u>					14. MOTHER'S MAIDEN NAME <u>Grace Beck</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-24-8865</u>		17. INFORMANT <u>Mr. G. Marvin Poe, 15 Milgate Rd., Mills, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - gastric</u> 151X DUE TO (b) <u>Metastasis to Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>---</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>---</u> e.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>February 25, 1966</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1967</u> , and that death occurred at <u>9:21 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>C.E. McWilliams</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>C.E. McWilliams, M.D.</u>					22d. ADDRESS <u>Reisterstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal Cem., Owings Mills, Md.</u>			23d. LOCATION (City, town or county) <u>---</u> (State) <u>---</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eckhardt</u>					ADDRESS <u>Owings Mills, Md.</u>		25. REC'D BY REGISTRAR <u>---</u> 26. REGISTRAR'S SIGNATURE <u>Johnas Jay</u>		
					DATE <u>MAR 23 1967</u>				

03313

CERTIFICATE OF DEATH

03302

IN WISCONSIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03314

03306

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS Manor Road		
3. NAME OF DECEASED (Type or print) First Adam Middle Popp Last Popp		4. DATE OF DEATH Month March Day 6 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-82	
9. AGE (In years) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor - retired		10b. KIND OF BUSINESS OR INDUSTRY Water Supply		
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN POPP		14. MOTHER'S MAIDEN NAME RACHEL GREEN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-38-8245		
17. INFORMANT Records: Spring Grove State Hospital		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 2-1-67 , 19 to March 6, 19 67 that (X) (we) last saw the deceased alive on March 6, 19 67 , and that death occurred at 9:30 M, from causes and on the date stated above.				
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 3-7-67		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY	23d. LOCATION (City or Town) (County) (State) PROVIDENCE BALTO. MD.	
24. FUNERAL DIRECTOR John Burns Somo		25a. REC'D BY REGISTRAR MAR 9 1967		
ADDRESS Towson		25b. REGISTRAR'S SIGNATURE Charles Judge		

03306

STATE OF NEW YORK

03316

State

County

City

Address

Occupation

Marital Status

Reason for admission

Age

Sex

Color

Religion

Education

Previous History

Present History

Admission Date: 1-17-12

Discharge Date: 1-17-12

Signature of Doctor

Signature of Patient

Signature of Nurse

Signature of Social Worker

Signature of Chaplain

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03315					03307						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY BALTIMORE					a. STATE Md						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY BALTO.						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
CATONSVILLE					CATONSVILLE						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
1505 KENT AVE.					1505 KENT AVE.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			MARY		M.		PRUITT		Month Day Year		
									3 26 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF FUNERAL 1 YEAR	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JULY 6, 1909		57 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
SEAMSTRESS								Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John W. Frey						MARGARET COLLINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
NO				213A49407		William H. PRUITT				1505 Kent Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)										7 days	
200X DUE TO											
(b)										10 years.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
(c)										10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
19											
21. I certify that (I) (this hospital) attended the deceased from 3/27/67 , 19 58 , to 3/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 3/17/67 , and that death occurred at 1:55 AM , from the causes and on the date stated above.											
22a. SIGNATURE				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
W E McGreth MD								3/27/67			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
W E McGreth MD				1303 Frederick Rd		Catonville Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL				3/30/67		Good Shepherd		Howard Co Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
E S. Mac Nabb				301 Frederick Rd Balto 28 Md				MAR 29 1967		J Charles Judge	

ALLEN

03307

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W. F. 10-2-1954

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03316

CERTIFICATE OF DEATH

03308

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>			13.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6210 Haddon Ave.</u>				d. STREET ADDRESS <u>6210 Haddon Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>J. B.</u> Last <u>Pugh</u>			4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 67</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Tel. Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212100371A</u>		17. INFORMANT <u>Catherine A. Pugh</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 3d DUE TO (b) <u>Carcinoma of Hypopharynx</u> DUE TO (c) <u>147X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>28 Mar</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>28 Mar</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>George J. Richards Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George J. Richards Jr.</u>				22d. ADDRESS <u>Greater Balt. Med. Center Balt 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20899

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03317

CERTIFICATE OF DEATH

03309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>How.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Catonsville/ Ellicott City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines-Catonsville</u>			d. STREET ADDRESS <u>810 Stayman Dr.</u> <u>House in the Pines</u> <u>116 Rusting Av Catonsville, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>B.</u> Last <u>Rackensperger</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1887</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Thomas Fletcher</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Frank C. McShane</u> Address <u>810 W. Stayman Dr- Ellicott City-Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular disease</u> DUE TO <u> </u> (c) <u> </u>					INTERVAL BETWEEN DNSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 20, 1960</u> , to <u>Mar 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 1, 1967</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Harry T. Knipp</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Mar 3, '67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Harry Knipp, M. D.</u>		22d. ADDRESS <u>4116 Edmondson Av.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F.D. - 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03303

STATE OF NEW YORK

03312

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03318					03310							
Item #11 Film #0300 3/9/67 pg												
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 2 Darvel Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HULDA Middle RADHE Last 4. DATE OF DEATH Month March Day 3 Year 1967												
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1891		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ? unknown			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 577-44-9316 A		17. INFORMANT S.G. Radhe, 2 Darvel Circle, Ellicott City			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 3561 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) AMYOTROPHIC LATERAL SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 6 M										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 12-28 , 1966 to 3-3 , 1967 , that (I) (we) last saw the deceased alive on FEB. 28 , 1967 , and that death occurred at 2:22 A.M. from the causes and on the date stated above.												
22a. SIGNATURE Peter J. Hinch					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-3-67				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-4-1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			23d. LOCATION (City, town or county) (State) Washington, D.C.				
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md.					25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge DATE MAR 6 1967							

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03311

FOR STATE
HEALTH DEPT

03319

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Baltimore ////////		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 02-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital Northern, Pkwy & Loch Raven		d. STREET ADDRESS 111 Elm Ave.	
3. NAME OF DECEASED (Type or print) First Charles Middle Lee Last Rains		4. DATE OF DEATH Month 3 Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/10 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
10b. KIND OF BUSINESS OR INDUSTRY Construction		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Rains		14. MOTHER'S MAIDEN NAME Mary Kouba	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no No		16. SOCIAL SECURITY NO. 217-14-6896	
17. INFORMANT Mr. Lee Rains (son)		18. ADDRESS 1007 Rosedale Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 20/67	23c. NAME OF CEMETERY OR CREMATORY Morgeland Memorial Pk.
24. FUNERAL DIRECTOR Singleton Funeral Home		23d. LOCATION (City or Town) (County) (State) Taylor Ave. Balto., Md.	
25a. REC'D BY REGISTRAR March 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03320

CERTIFICATE OF DEATH

03312

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u>		c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>512 E. Seminary Ave</u>				d. STREET ADDRESS <u>512 Seminary Ave, East</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Frederick Redding</u>				4. DATE OF DEATH Month Day Year <u>March 3 19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1900</u>		9. AGE (In years lost birthday) yrs. <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Contracting</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Redding</u>				14. MOTHER'S MAIDEN NAME <u>Eleanora Coker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 09 9852</u>		17. INFORMANT Address <u>Bruce Redding, Timonium, Md. 21093</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19 56</u> , to <u>2/3 1967</u> , that (I) (we) last saw the deceased alive on <u>2/3 1967</u> , and that death occurred at <u>12:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William F. Renner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm F. Renner</u>				22d. ADDRESS <u>3222 St. Paul St. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3, 6, 57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Baltimore, Md</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>				25. REG'D BY REGISTRAR DATE <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03321

CERTIFICATE OF DEATH

03313

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8 RIDGE RD.		d. STREET ADDRESS 8 RIDGE RD	
3. NAME OF DECEASED (Type or print) EMMA BELLE REED First Middle Last		4. DATE OF DEATH MARCH 16 1967 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/84 Yrs. 82
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY	
10. BIRTHPLACE (County & State, or foreign country) MD.		11. CITIZEN OF WHAT COUNTRY?	
12. FATHER'S NAME JOSEPH W. LANKFORD		13. MOTHER'S MAIDEN NAME MARY MADDOX	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		15. SOCIAL SECURITY NO.	
16. INFORMANT MRS ELSIE DOVE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from March , 19 62 to March , 19 67 , that (I) (we) last saw the deceased alive on Feb. 21 , 19 67 , and that death occurred at 6:45 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Leo J. Gaver, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED March 17, 1967
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE	23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD.
24. FUNERAL DIRECTOR E.S. MALNARB		ADDRESS 301 FREDERICK RD 21228	25a. REC'D BY REGISTRAR MAR 20 1967 DATE
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

0335

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03322

CERTIFICATE OF DEATH

03314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21204		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1644 Naturo Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Margaret Last REITZEL				4. DATE OF DEATH Month March Day 1 Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 27, 1906		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? McGuiness				14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218-05-3090		17. INFORMANT Mr. Samuel S. Reitzel Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 , to March 1, 1967 , that (I) (we) last saw the deceased alive on March 1, 19 67 , and that death occurred at 12:40M , from causes and on the date stated above.								
22a. SIGNATURE Teodulo Paglinauan, Jr.				P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 1, 1967		
22c. PHYSICIAN'S NAME (Type) Teodulo Paglinauan, Jr. M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/67.	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR MAR 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		

41830

33330

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

Very respectfully,

Sincerely yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

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Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Charles D. Johnson

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03323 Item #12 Film A1501 4/5/61 pg 03315											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> 13-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1116 KENT AVE.</u>						d. STREET ADDRESS <u>1116 KENT AVE</u>					
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>N.</u> Last <u>Richardson</u>						4. DATE OF DEATH Month <u>MAR</u> Day <u>28</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>London England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Richardson</u>						14. MOTHER'S MAIDEN NAME <u>Emily BOBB</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>T.D. Nichols</u> Address <u>1116 KENT AVE. CATONSVILLE 28, MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Generalized Atherosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 19 66</u> to <u>March 28 1967</u> , that (I) (we) last saw the deceased alive on <u>March 19 67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thos T Abbott</u>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		23d. LOCATION (City, town or county) (State) <u>ELK RIDGE MD.</u>			
24. FUNERAL DIRECTOR <u>F.C. Higginbotham</u>						ADDRESS <u>ELICOTT CITY, MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03324

CERTIFICATE OF DEATH

Reg. Dist. No.

03316

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 KINSHIP ROAD				d. STREET ADDRESS 69 NORTHSHIP ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET EUGENIA RILEY				4. DATE OF DEATH Month Day Year MARCH 21, 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1911		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSIONAL TEACHER PUBLIC SCHOOLS				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE X. RILEY				14. MOTHER'S MAIDEN NAME MARGARET MORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-38-3746		17. INFORMANT PAUL RILEY Address 2967 LIBERTY PARKWAY DUNDALK MD. 21222			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on MARCH 21, 1967 , and that death occurred at 10:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 DUNDALK AVE. DATE SIGNED 3/23/67							
ACTUAL SIGNATURE Benigno R. Lazard M.D.				DATE SIGNED 3/23/67			
PHYSICIAN'S NAME (Type) BENIGNO R. LAZARD, MD.				DUNDALK 21222, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/67		22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE MEMORIAL		22d. LOCATION (City, town, or county) (State) DORSEY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER BROOKS BRADLEY, INC., DUNDALK				24a. RECEIVED BY REGISTRAR MAR 27 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03325					03317						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		Baltimore Co.			a. STATE		b. COUNTY				
		MARYLAND			Maryland		Baltimore Co				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Towson			Six Months		Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
711 Fairway Drive					711 Fairway Drive						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
First Middle Last					March 22, 1967						
Helen Ringger											
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Nov. 20, 1890		76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Seamstress					Germany		USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Ernest Remler					Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
No					216-16-5820		Marcella R. Kempf (Daughter)			Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARE: NEMATODES										8 mos	
180X DUE TO (CA - Kidney)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1966 to March 22, 1967, that (I) (we) last saw the deceased alive on 3-22-1967, and that death occurred at 12:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Dr. S. J. Venable, Jr.					3-22-67						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
					7215 York Road Baltimore Md 21212						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		March 25, 1967		Gardens of Faith Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Eugenia K. Seitz 5209 York Road					MAR 27 1967			Charles Judge			
Seitz Funeral Home Baltimore, Md. 21212											

CERTIFICATE OF DEATH

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MAR 21 1967

03326

CERTIFICATE OF DEATH

03318

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS WHITE HALL	
3. NAME OF DECEASED (Type or print) First WALTER Middle P. Last RITZMANN		4. DATE OF DEATH Month MARCH Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY Paper mill	9. AGE (In years last birthday) yrs. 59
13. FATHER'S NAME JOSEPH F. RITZMANN		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 217 14 19 89		14. MOTHER'S MAIDEN NAME CATHERINE STRIETMALLER	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RIGHT LUNG WITH METASTASIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if in this hospital) attended the deceased from 3/18/67 , 19____, to 3/19/67 , 19____, that (H) (we) last saw the deceased alive on 3/19/67 , 19____, and that death occurred at 8:45 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY WISEBURG CEMETERY	23d. LOCATION (City or Town) (County) (State) WHITE HALL, MARYLAND
24. FUNERAL DIRECTOR <i>Jacob Hartenstein</i>		25. REC'D BY REGISTRAR MAR 23 1967	
ADDRESS HARTENSTEIN FUNERAL HOME		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
NEW FREEDOM, PENNSYLVANIA			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03327											
1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14R. 3 mo. 26th. Towson</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>						d. STREET ADDRESS <u>2 PROSPECT CIRCLE</u>					
3. NAME OF DECEASED (Type or print) First <u>H.</u> Middle <u>MAY</u> Last <u>Robbins</u>						4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred HUGHES</u>						14. MOTHER'S MAIDEN NAME <u>C. VAN Duser</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>140-18-3728</u>		17. INFORMANT <u>Mrs. HUDGINS</u> Address <u>1643A WAVERLY WAY LOCH RAVEN APT. #12</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>465X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Generalized</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 3, 1965</u> , to <u>March 2, 1967</u> , that (2) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>David J. Miller</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 2-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David J. Miller</u>						22d. ADDRESS <u>Linson Rd. - Owings Mills, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE THEREOF <u>3/2/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>West Long Branch, N. J.</u>			
24. FUNERAL DIRECTOR <u>Wm. F. Tichenor & Sons</u>						ADDRESS <u>Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 2 1967</u>											

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03351

Removal of Embolus

Atherosclerosis Generalized

David J. Miller
David J. Miller

MAR 2 1987

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03320

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville 03-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1512 York Road				d. STREET ADDRESS 1512 York Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta M. Rockel				First Middle Last		4. DATE OF DEATH Month 31 Day 24 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1890		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Trainor				14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Roland A. Rockel		16 W. Seminary Ave. Lutherville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio- DUE TO Renal/Vascular Disease (c) 10 yrs								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Not a natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 3/24/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/1967		23c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery			23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24. FUNERAL DIRECTOR Wm. Fickner & Sons				ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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03329

CERTIFICATE OF DEATH

03321

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3511 Foxcliff Court, Apt 104</u>		d. STREET ADDRESS <u>3511 Foxcliff Court, Apt 104</u>	
3. NAME OF DECEASED (Type or print) <u>Nathan Rosen</u>		4. DATE OF DEATH <u>March 22,</u> 19 <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1906</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB ROSEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>090-07-2984</u>	
17. INFORMANT <u>Mrs. Toby Rosen, 3511 Foxcliff Court, Apt 104</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs.</u> <u>15 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>MAR 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR 17, 1967</u> , and that death occurred at <u>11 p.</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Albert J. Himelfarb</u>		22b. DATE SIGNED <u>3/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J. HIMELFARB</u>		22d. ADDRESS <u>3501 ST. PAUL ST. BALTO. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>RANDALLSTOWN, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03330					03322						
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - TOWSON 21204			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE 30-4						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GBMC					d. STREET ADDRESS 400 EAST 28th ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SEBASTIAN			First Middle Last ROSSKOPF		4. DATE OF DEATH Month MAR. Day 3 Year 1967						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/00		9. AGE (In years last birthday) 67 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) BAVARIA GERMANY			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME SEBASTIAN, ROSSKOPF				14. MOTHER'S MAIDEN NAME FRANCISCA MYERS MAYER							
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) NONE			16. SOCIAL SECURITY NO. 219-32-0758		17. INFORMANT Address MRS. ROSA ROSSKOPF (SAME)						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Ca Lung 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Carcinoma of Lung with (c) metastases								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from March 2, 1967 to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 1:45 AM , from the causes and on the date stated above.											
22a. SIGNATURE Ram K. Chhillar					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/3/67				
22c. PHYSICIAN'S NAME (Type) RAM K. CHHILLAR					22d. ADDRESS Ctr. BALTO. MED. CENTER BALTIMORE, MD. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/6/1967		23c. NAME OF CEMETERY OR CREMATORY Glen Haven			23d. LOCATION (City, town or county) (State) Anne Arundel Cty. Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.					25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

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James K. Williams
James K. Williams

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J. H. B. 10000, 10000, 10000
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CERTIFICATE OF DEATH

03331

03323

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, --Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 814 Old North Point Road,		d. STREET ADDRESS 814 Old North Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA		First Middle Last RULENZ		4. DATE OF DEATH Month Day Year March 5, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Poland	
13. FATHER'S NAME John Tiess		14. MOTHER'S MAIDEN NAME Minnie Buodowski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Anna R. McColligan 814 Old North Point Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arterio-sclerosis - Cardio Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		2Dd. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1965 , to March 5, 1967 , that (I) (we) last saw the deceased alive on March 5, 1967 , and that death occurred at 11 A , from the causes and on the date stated above.					
22a. SIGNATURE Morris A. Jacobs		M.D. 22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs, M.D.		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1010 North Point Road,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 8, 1967		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery Colgate, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		ADDRESS		25a. REC'D. BY REGISTRAR MAR 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

03324

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>(Parkville) Balto. 21234</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hosp.</u>		d. STREET ADDRESS <u>7613 Old Harford Road</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1893.</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Stavros Nikolopoulos</u>		14. MOTHER'S MAIDEN NAME <u>Athena Panagiotopoulos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>102-07-7464B</u>	
17. INFORMANT <u>Mr. Peter Sakell</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>Mar. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes on and the date stated above.			
22a. SIGNATURE <u>R Donald Jaudorf</u>		22b. DATE SIGNED <u>3-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R Donald Jaudorf</u>		22d. ADDRESS <u>6077 Harford Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/13/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

03325

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. LENGTH OF STAY IN lb <u>2 Mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		21207	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-la Nursing Home</u>		d. STREET ADDRESS <u>1108 Landington Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Concetta</u> Middle <u>NMN</u> Last <u>Sola</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Apr 1880</u>
9. AGE (In years lost birthday) yrs. <u>86</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Anthony Traci</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>21-54-5744J1</u>	
17. INFORMANT <u>Nursing Home</u>		Address <u>Ches</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>General Debilitation</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>21 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> , 19 <u>67</u> , to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>67</u> and that death occurred at <u>6:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Zickel</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>415 W. Lane, Elkton City, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/25/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03332

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

03326

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lowson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 15 Delight Avenue	
3. NAME OF DECEASED (Type or print) First FONTELLA Middle L. Last SAMPLES		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1900.
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mills		14. MOTHER'S MAIDEN NAME Mary E. Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles Sommers		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4331 IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease DUE TO (b) Terminal Ventricular Arrhythmia DUE TO (c) fibrillation			INTERVAL BETWEEN ONSET AND DEATH onset
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June, 1967 to 28 Mar 1967 that (I) (we) last saw the deceased alive on 28 Mar 1967 , and that death occurred at 2:40 M, from causes and on the date stated above.			
22a. SIGNATURE John C. Hyle		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN C. HYLE		22d. ADDRESS 7527 Belknap Blvd 36	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/67.	
23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City or Town) (County) (State) Kansas City, Missouri.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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CERTIFICATE OF DEATH

03327

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1608 ELLSWORTH STREET	
3. NAME OF DECEASED (Type or print) First WALTER Middle DOUGLAS Last SANDERS		4. DATE OF DEATH Month MARCH Day 5 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 5, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 61
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLIE SANDERS		14. MOTHER'S MAIDEN NAME ELIZABETH TATE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) PSEUDOMONAS AERUGINOSA DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOSIS OF THE RIGHT MIDDLE CEREBRAL ARTERY. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that WALTER DOUGLAS SANDERS (this hospital) attended the deceased from FEB 28 , 19 67 , to MARCH 5 , 19 67 , that he (we) lost saw the deceased alive on MARCH 5 , 19 67 , and that death occurred at 150P M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-9-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR RAYNOR SANDERS		25a. REC'D BY REGISTRAR DATE MAR 13 1967	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>
FUNERAL HOME, 217 E. Preston ST, Baltimore			

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BALTIMORE

2 DAYS

FRT BOARD

1606 ELLSWORTH STREET

VETERANS ADMINISTRATION HOSPITAL

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MARCH

SIXTHS

DECEMBER

WINTER

SEPTEMBER 2, 1902

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SECOND

RAIL

BALTIMORE, MARYLAND

MARCH

SIXTHS

CHARLES SANDERS

VA HOSPITAL

CLINICAL RECORDS, FRT BOARD, MARYLAND

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CHRONIC DISEASE

CHRONIC DISEASE

THE BOARD OF THE FRT BOARD, MARYLAND, MARYLAND

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MARCH 2, 1902

SEP 26

MARCH 2, 1902

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WAS 2ND BOARD, MARYLAND

FRANK V. JONES, M. D.

BALTIMORE, MARYLAND

BALTIMORE NATIONAL

BALTIMORE

RAYMOND SANDERS

GENERAL HALL, 217 N. PRINCE ST., BALTIMORE

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<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>03336</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>03328</p> </div> </div>											
1. PLACE OF DEATH a. CDUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>✓</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>				c. LENGTH OF STAY IN 1b <i>30-4</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Milford MANOR Nursing Home</i>				d. STREET ADDRESS <i>3007 Liberty Hts.</i> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>BERTH A</i> Middle <i>SARUBIN</i> Last <i>SARUBIN</i>				4. DATE OF DEATH Month <i>MARCH</i> Day <i>11</i> Year <i>1967</i>							
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 30, 1903</i>		9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months <i>11</i> Days <i>19</i> Hours <i>67</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Paul Peschal</i>				14. MOTHER'S MAIDEN NAME <i>Hinda ?</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>UNKNOWN</i>				16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>ATAOLLAH GOLPIRA, MD. - 1942 CEDAR LANE</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Colon with wide spread metastasis</i> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Oct.</i> , 19 <i>66</i> , to <i>March 10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 9</i> , 19 <i>67</i> , and that death occurred at <i>2:35</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Ataollah Golpira</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>March 11, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>ATAOLLAH GOLPIRA</i>				22d. ADDRESS <i>1942 Cedar Lane, Balto, Md. 21222</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/12/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beth Yeshon Cong</i>		23d. LOCATION (City, town or county) (State) <i>Balto Md.</i>					
24. FUNERAL DIRECTOR <i>Sol Korman & Bros Inc</i>				ADDRESS <i>6010 Reisterstown Rd</i>		25a. REC'D BY REGISTRAR <i>14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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M.A.

Butterworth

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Female DATE

March 1932

UNCLASSIFIED

Office of the Secretary of the
Department of the Interior
Washington, D.C.

March 9 1932
Atoll Islands

ATOLL ISLANDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #0 Film #G386 3/9/67 py

03337

CERTIFICATE OF DEATH

03329

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. #21204				d. STREET ADDRESS 4312 Walther Avenue #21214	
3. NAME OF DECEASED (Type or print) First FLORENCE		Middle M.		Last SCHAFER	
4. DATE OF DEATH Month 3-		Day 5		Year 67	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-28-95		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Durham		14. MOTHER'S MAIDEN NAME Lottie Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 183-05-2682		17. INFORMANT Miss Phyllis Schafer-Daughter Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar artery thrombosis 332X DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from 3-4- , 19 67 , to 3-5-67 , 19 67 , that (X) (we) last saw the deceased alive on 3-5- , 19 67 , and that death occurred at 19:00 , from causes and on the date stated above.					
22a. SIGNATURE Lawrence J. Misanik		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-5-67	
22c. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10000

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03338

CERTIFICATE OF DEATH

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>53 Briarwood Rd.</u>			d. STREET ADDRESS <u>53 Briarwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Theckla C. Schifferer</u>			4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18/82</u>		9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frederick Schifferer</u>			14. MOTHER'S MAIDEN NAME <u>Katherine ---</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-32-4176A</u>	17. INFORMANT <u>Mrs. Eileen E. Eiser</u> Address <u>53 Briarwood Rd. - 21228</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>66</u> , to <u>3/15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>67</u> , and that death occurred at <u>4:35</u> M, from causes and on the date stated above					
22a. SIGNATURE <u>Robert A. Reiter</u>			22b. DATE SIGNED <u>3/16/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>			22d. ADDRESS <u>606 Edmondson Ave 21228</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Ellicott City, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 17 1967</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore		c. LENGTH OF STAY IN lb 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Augsburg Lutheran Home 6811 Campfield Road 21207		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Christina Middle Elizabeth Last Schilling		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/80
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Rehling		14. MOTHER'S MAIDEN NAME Barbara Rithman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-50-9423-01	
17. INFORMANT Paul A. Hauer, 6811 Campfield Road		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease (Failure) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho-pneumonia DUE TO (c) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 5 years 4 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio Sclerotic Changes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 66 , to March 4 , 19 67 , that (I) (we) last saw the deceased alive on March 3 , 19 67 , and that death occurred at 4 P. M, from causes and on the date stated above.			
22a. SIGNATURE Earl L. Chambers		22b. DATE SIGNED 3/5/67	
22c. PHYSICIAN'S NAME (Type) Earl L. Chambers		22d. ADDRESS 4108 Liberty St - Balto - Md	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY Western Cove		23d. LOCATION (City or town) (County) (State) Balto Md	
24. FUNERAL DIRECTOR W. Deemann 6062 Harf Rd		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF TEXAS

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COUNTY OF DALLAS

JANUARY 1, 1971

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JANUARY 1, 1971

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY 8811 Jasper Lane Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 8811 Jasper Lane, Balto. Co., Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN lb lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8811 JASPER LANE		d. STREET ADDRESS 8811 JASPER LANE	
3. NAME OF DECEASED (Type or print) Elizabeth A Schultz		4. DATE OF DEATH Month March Day 25 Year 1967	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-93
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edgar Bissell	
14. MOTHER'S MAIDEN NAME Ruth Ann Roberts		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Other sclerotic Cardiovascular 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1964 , to 3-24, 1966 that (I) (we) last saw the deceased alive on 3-23, 1967 and that death occurred at 6p M. from causes and on the date stated above.			
22a. SIGNATURE John C. Hyle		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3-27-67
22c. PHYSICIAN'S NAME (Type) Dr. John C Hyle		22d. ADDRESS 7527 Belair Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/28/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk	23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Md.
24. FUNERAL DIRECTOR CHARLES F EVANS & SON Balto., Md. 2123		25a. REC'D BY REGISTRAR MAR 29 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

0330

CERTIFICATE OF DEATH

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1. NAME OF DECEASED (Type or Print) EDWARD L. SCHWARTZ		2. DATE AND HOUR OF DEATH 3-31-67	
3. PLACE OF DEATH IN BALTIMORE-MARYLAND BALTIMORE COUNTY FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 58 St. Joseph's TOWSON - 21204		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 903 S. Conkling St.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-1-1911
9. AGE (In years lost birthday) 55		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PBX Installer		10B. KIND OF BUSINESS OR INDUSTRY C + P. Telephone Co.	
11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George E		14. MOTHER'S MAIDEN NAME Mary Lober	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-0613	
17. INFORMANT Mrs. Thelma Schwartz		ADDRESS 903 S. Conkling St.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4201		CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Myocardial Infarct (C)	
22. I certify that (I) (this hospital) attended the deceased from MARCH 25 1967 to MARCH 31 1967 that (I) (we) last saw the deceased alive on March 31, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Andrzej Kunikowski M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Andrzej Kunikowski M.D.		23D. ADDRESS 7529 Eastern Ave - 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 4-3-67	24C. NAME OF CEMETERY or CREMATORY Greenmount	24D. LOCATION (City, town, or county) (State) Balto Md.
25A. DATE REC'D BY HEALTH DEPT. APR 5 1967	25B. NAME OF REGISTRAR Charles Judge	25C. FUNERAL DIRECTOR Thelma A. Hoffmann ADDRESS 3218 Hudson St	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 remain in the original and should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 45 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 406 MURDOCK ROAD	
3. NAME OF DECEASED (Type or print) ALEXANDER		4. DATE OF DEATH Month MARCH Day 20 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1878
9. AGE (In years and birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SEAMON		14. MOTHER'S MAIDEN NAME ANNA SHENDERMEISER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) VBO		16. SOCIAL SECURITY NO. 217 03 66 74	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. DECUBITIS, MULTIPLE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/3/67 , 19__, to 3/20/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/20/67 , 19__, and that death occurred at 11:00AM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/22/1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR JENKINS FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAR 21 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Juvan</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03343

CERTIFICATE OF DEATH

03335

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore TOWSON</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>721 Hickory Lot Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amy Moriva Sears</u>		4. DATE OF DEATH Month Day Year <u>MARCH 19 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1895</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Trenton, New Jersey</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Edward Hart Giles</u>		16. MOTHER'S MAIDEN NAME <u>Anna Hurmston</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		18. SOCIAL SECURITY NO. <u>717-07-69</u>	
19. INFORMANT <u>COL. WELLINGTON B. SEARLES</u> (Patients Chart)		Address <u>(SAME)</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibrosarcoma of ovary, Rt. with</u> DUE TO (b) <u>Generalized metastasis</u> DUE TO (c) <u>1750</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>15 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	22d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 7</u> , 1967, to <u>March 19</u> , 1967, that (we) last saw the deceased alive on <u>March 19 1967</u> , and that death occurred at <u>4:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Shelley</u>		22b. DATE SIGNED <u>March 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Stuart Sunday</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>	
ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03880

CERTIFICATE OF DEATH

03880

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03344

CERTIFICATE OF DEATH

03336

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 years +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in The PINES - 16 FUSTING AVE</u>				d. STREET ADDRESS <u>144 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH SCITZ</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1889</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home - wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley E. Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Jungling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>George L. Stroup</u> Address <u>411appa Road, Carroll, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>1037'</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-30-</u> , 19 <u>64</u> , to <u>3-6-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-6-</u> 19 <u>67</u> , and that death occurred at <u>2038</u> P.M., from causes and on the date stated above							
22a. SIGNATURE <u>Wilmer K. Gallagher Sr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher Sr.</u>				22d. ADDRESS <u>6209 Frederick Ave. Baltimore 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Westminster Md.</u>			
24. FUNERAL DIRECTOR <u>J.E. Myers Jr.</u>		ADDRESS <u>Westminster Md.</u>		25a. RECEIVED BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

42880

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03345				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				03337			
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON # 13-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1313 MILL DAM RD						d. STREET ADDRESS 1313 MILL DAM RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First FREDERICK Middle SEYBOTH Last						4. DATE OF DEATH Month MARCH Day 30 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-4-99		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die maker				10b. KIND OF BUSINESS OR INDUSTRY Black & Becker		11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Seyboth						14. MOTHER'S MAIDEN NAME Rose Kuebler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 122-10-9867		17. INFORMANT Address Mrs Adelaide L. Seyboth 1313 Milldam Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CORONARY ARTERY DISEASE DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE William A. Pillsbury M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 3-30-67		
EXAMINER'S NAME (Type) William A. Pillsbury						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge Address (Street, City, Town, or County)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.			
24. FUNERAL DIRECTOR Lassalman and Home 2401 Belair Road						25a. REC'D BY REGISTRAR DATE APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

1937

1937

Handwritten notes and signatures in the top right corner, including a large circular mark.

Main body of the document containing faint, mostly illegible text and lines, possibly representing a ledger or form.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03338

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 1525 Pentridge Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Dessel Last Shamberger		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1890
9. AGE (In years 76 birthday) yrs.		IF UNDER 1 YEAR Months 7 Days 6 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Dessel		14. MOTHER'S MAIDEN NAME Mary Sauers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elaine M. Peck		Address 322 Worthington Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 Requesting Autopsy DUE TO (b) Abdominal Aortic DUE TO (c) Lymph Sarcoma		INTERVAL BETWEEN ONSET AND DEATH Sixteen-1 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 3/28/67			
23a. BURIAL, CREMATION, REBURY Burial		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto., Md. 21212	
25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03347											
03339											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>				c. LENGTH OF STAY IN 1b <u>60 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> <u>03-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>00 Kingsville, Maryland</u>						d. STREET ADDRESS <u>Kingsville, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Bradley Shepperd</u>						4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Francis Graydon Shepperd</u>						14. MOTHER'S MAIDEN NAME <u>Mary Bradley Shepperd</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-22-9853</u>		17. INFORMANT <u>Regina B. Shepperd</u> Address <u>Kingsville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Insufficiency</u> <u>4221</u> DUE TO (b) <u>Cardio Vascular CVD</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA</u> 1962 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>March</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-13</u> 1967, and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William G. Tyson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>						22d. ADDRESS <u>Kingsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 18 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHEN CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>BRADSHAW MD</u>			
24. FUNERAL DIRECTOR <u>THE DIPPEL BROS INC</u>						ADDRESS <u>7110 BELAIR ROAD</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1933

1933

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03348

CERTIFICATE OF DEATH

03340

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Balt. Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roadsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt.</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>5000 A Lincol Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balt. Co. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathan</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/75</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-9424</u>	
17. INFORMANT <u>Mrs. Rosalie Racusin</u>		Address <u>3609 Briarstone Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>Cerebrovascular Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>67</u> , to <u>3/1</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>3/1</u> 19 <u>67</u> , and that death occurred at <u>2:10</u> P.M., from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. De Joya</u>		22b. DATE SIGNED <u>3/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. De Joya</u>		22d. ADDRESS <u>B. C. G. H.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Abnath Shalom</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25. REGISTRY BY REGISTRAR <u>MAR 6 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03343

CERTIFICATE OF DEATH

03341

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN 1b <u>137</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>27 WARREN PARK DRIVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>27 WARREN PARK DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ABRAHAM</u> <u>SILBERMANN</u> <u>MARCH</u> <u>10</u> <u>1967</u>				4. DATE OF DEATH Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 22, 1913</u>	
9. AGE (in years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>NOT KNOWN</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>091-26-8012</u>		17. INFORMANT <u>MRS HENIA SILBERMANN</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1992</u> <u>Acute pulmonary edema</u> DUE TO (b) <u>marked anemia</u> DUE TO (c) <u>Chondrosarcoma, malignant</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few months</u> <u>months</u> <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 21, 1966</u> to <u>March 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>4:40</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis R. Maser</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS R. MASER M.D.</u>				22d. ADDRESS <u>2724 SMITH AVE., BALTIMORE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial & Rem.</u>		23b. DATE THEREOF <u>3/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Israel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Israel</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis & Son, Inc</u> ADDRESS <u>Harwood, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>	

10380

CHITRAKUT OF DASH

03843

[Faint, mostly illegible handwritten text and markings across the page, possibly bleed-through from the reverse side. Some words like "CHITRAKUT" and "DASH" are visible.]

03350

CERTIFICATE OF DEATH

03342

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 3102 Rueckert Avenue	
3. NAME OF DECEASED (Type or print) First John Middle S. Last Sinclair		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry F. Sinclair		14. MOTHER'S MAIDEN NAME Ann L. Wehn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never or unknown) (If yes give war or dates of service) yes WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary L. Schwartz		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Febr. 19, 1966 , to March 4, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 11:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Cesario J. Pellegrino		22b. DATE SIGNED March 4, 1967	
22c. PHYSICIAN'S NAME (Type) Cesario J. Pellegrino		22d. ADDRESS 6800 Loch Raven Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/7/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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PERSONAL DATA		FAMILY DATA		EDUCATION		OCCUPATION		MILITARY SERVICE		REMARKS	
NAME	LAST FIRST MIDDLE	FATHER'S NAME	MOTHER'S NAME	SCHOOL	DEGREE	DATE	PLACE	BRANCH	GRADE	DATE	REMARKS
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03351

CERTIFICATE OF DEATH

03343

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MD. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>4024 Coldspring Lane</u>	
3. NAME OF DECEASED (Type or print) <u>YETTA</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>80</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Laib Brodie</u>		14. MOTHER'S MAIDEN NAME <u>Leah ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>205-14-4231</u>	
17. INFORMANT <u>Mr. Joseph Sitnick, 4024 W. Cold Spring Lane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUSPECTED OCCLUSION OF AORTIC BIFURCATION</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>454X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ULCERATIVE COLITIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/18/67</u> , 19____, to <u>3/24/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>3/24/67</u> , 19____, and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Irvin Hyatt Ormrod</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR IRVIN HYATT</u>		22d. ADDRESS <u>Baltimore Co. General Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tifereth Israel Anshe Shard</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Lewenson & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>6010 Rust. Rd.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 29 1967	



03352

CERTIFICATE OF DEATH

Reg. Dist. No. 03344

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Coleridge Court, Apt. E				d. STREET ADDRESS 1002 Coleridge Court, Apt. E			
3. NAME OF DECEASED (Type or print) Mildred F. Sline				4. DATE OF DEATH Mar. 25 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 1, 1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Upholstery Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Franklin H. Barto				14. MOTHER'S MAIDEN NAME Emma L.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-0828		INFORMANT Address 21228 Mrs. Irvin R. Waterfield, 1322 Denbriht Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA - Left 1969 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fumar - Skull - Pelvic Bones. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month. Day. Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Jan 11 , 1966, to Mar 26 , 1967, that I last saw the deceased alive on Mar 25 , 1967, and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph S. Blum, M.D.		M.D. 1115 N. CALVERT ST.		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD		BALTO - 2-MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 28, 1967	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave., Balto. 29, Md.			24a. REC'D BY REGISTRAR MAR 28 1967		24b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03345

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>4 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H. Joseph's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELsie C. SMITH</u>		4. DATE OF DEATH <u>3/6</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/04</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Janie Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-48-9678</u>	
17. INFORMANT <u>Jas. R. Smith - Cockeysville, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 260X DUE TO (b) <u>Dehydrate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertension and Cardiac Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10+ yrs.</u> <u>10+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22. DATE SIGNED <u>3/6/67</u>	
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lough's</u>	23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Balto., Co. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. L. Chatman Jr. - 1701 Mt. Cullow St. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

032220

032220



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03354

03346

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>13-1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 Westowne Rd.</u>				d. STREET ADDRESS <u>221 Westowne Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>A.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1887</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Holmes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Black</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-01730</u>		17. INFORMANT Address <u>Mr. G. WALTER Smith 505 Kingston Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>6000 Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized Arteriosclerosis</u> (c) <u>Pericarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>3/29</u> 1967, that (I) (we) last saw the deceased alive on <u>3/28</u> 1967, and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James Nolan</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J S NOLAN MD</u>				22d. ADDRESS <u>Baltimore MD 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PK.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury, Sr.</u>				ADDRESS <u>6411 Windsor Mill Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03886

CERTIFICATE OF DEATH

03886

Blank certificate form with faint horizontal lines and a large rectangular box in the center.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03355		CERTIFICATE OF DEATH		03347	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randall's town</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>			d. STREET ADDRESS <u>3129 Jeffland Road 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>E.</u> Last <u>Smithson</u>			4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb. 10, 1880</u>		9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Harford County</u>	
13. FATHER'S NAME <u>William B. Smithson</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-44-1293 T</u>		17. INFORMANT <u>Mr. James A. Smithson</u> Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prolonged hypotension - car-</u> DUE TO <u>diogenic in origin 2° Gen.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>ASCD.</u> (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>67</u> , to <u>3-5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>67</u> , and that death occurred at <u>11:32 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>L. Junior</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-5-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centre Methodist Cemetery Forest Hill, Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tinker - same as above</u>		ADDRESS <u>Balto., Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03356

CERTIFICATE OF DEATH

03348

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle B Last SOMERS		4. DATE OF DEATH Month MARCH Day 31 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 1919
9. AGE (In years last birthday) yrs. 48		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCKER ROOM ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL BOARD	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARZA SOMERS		14. MOTHER'S MAIDEN NAME MARGARET SLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 216 09 97 42	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE YELLOW ATROPHY OF LIVER 580X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE. FRACTURE LEFT HIP		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that IV (this hospital) attended the deceased from MARCH 11 , 19 67 , to MARCH 31 , 19 67 , that IV (we) last saw the deceased alive on MARCH 31 , 19 67 , and that death occurred at 500A M, from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick MD</i> M.D.		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4 3 67	
23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) RITCHIE HIGHWAY, BALTO. MD.	
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE BALTIMORE, MD.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03357

CERTIFICATE OF DEATH

03349

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN Tb 55 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 5621 Wesley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANGRISH (NMI) SPEARMAN				4. DATE OF DEATH Month Day Year MARCH 2ND 19 67			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/17/94	
9. AGE (In years last birthday) 72 (72 yrs.)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman				10b. KIND OF BUSINESS OR INDUSTRY Steamship Lines		11. BIRTHPLACE (County & State, or foreign country) Fayetteville, North Carolina U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Marshall Spearman				14. MOTHER'S MAIDEN NAME Rose Cogden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-09-33-31		17. INFORMANT Address Clinical Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 3 Days YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 9 , 19 66 , to March 2 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 2 , 19 67 , and that death occurred at 1:20PM , from causes and on the date stated above.							
22a. SIGNATURE Louis C. Breschi, M.D.				22b. DATE SIGNED 3/2/67		22c. PHYSICIAN'S NAME (Type) LOUIS C. BRESCHI, M.D.	
22d. ADDRESS VA HOSPITAL, FORT HOWARD, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 7/67		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Elliott Funeral Home				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF JUSTICE

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CERTIFICATE OF DEATH

03350

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3315 Ripple Rd.</u>		d. STREET ADDRESS <u>3315 Ripple Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>IRVIN SPECTOR</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>MARCH 18, 1967 9PM 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-8400</u>	
17. INFORMANT <u>Mrs. Bertrum Kammerman- Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>generalized atherosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>66</u> , to <u>3/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>67</u> and that death occurred at <u>9:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Leonard Golombeck</u>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leonard Golombeck</u>		22d. ADDRESS <u>7039 Liberty Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Eliloh Cong.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC. 6010 Reist Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03353

CERTIFICATE OF DEATH

03351

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings, Mills		c. LENGTH OF STAY IN lb 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 924 Ashland Court	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Monica Middle Yvonne Last Spellman		4. DATE OF DEATH Month 3 Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/62
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Johns Hopkins Hosp.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Spellman		14. MOTHER'S MAIDEN NAME Yvonne Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address Owings Mill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Aspiration of stomach contents DUE TO (c) 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kernicterus with Chronic brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 11-26 , 19 63 , to 3-11 , 19 67 , that (we) last saw the deceased alive on 3-11 , 19 67 , and that death occurred at 11:45 from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 14 Mar 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY Rosewood		23d. LOCATION (City or Town) (County) (State) Owings Mills Md	
24. FUNERAL DIRECTOR J F FELINE & Sons		25. REGISTERAR'S SIGNATURE Charles Judge	
25a. DATE MAR 20 1967		25b. REGISTERAR'S SIGNATURE Charles Judge	

03353

03351

CERTIFICATE OF DEATH

STATE OF NEW YORK

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Cause of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Medical Examiner	
Signature of Undertaker		Signature of Burial Place	
Signature of Family		Signature of Friends	
Signature of Church		Signature of Community	
Signature of State		Signature of Nation	

Department of Social Services
Administration of Social Services

Records and Information Systems

Richard A. Jones
Richard A. Jones

Resident of the State

03360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON (VALLEY ROAD)	
c. LENGTH OF STAY IN lb 3 YRS.		d. STREET ADDRESS VALLEY ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILBUR LEROY SPRECKER		4. DATE OF DEATH Month MARCH Day 6 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1913
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) NEWVILLE, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARL SPRECKER		14. MOTHER'S MAIDEN NAME PEARL L. GORMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 213-05-1547	
17. INFORMANT MRS. MARY D. SPRECKER		Address VALLEY ROAD STEVENSON, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		22. DATE SIGNED 3-7-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/67	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Frederick, Md.	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03361

CERTIFICATE OF DEATH

03353

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - ESSEX</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1642 Rickenbacker Road.</u>		d. STREET ADDRESS <u>1642 Rickenbacker Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>R.</u> Last <u>Squires</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1934</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Ratajczak</u>		14. MOTHER'S MAIDEN NAME <u>Rose Lhotsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-34-2223</u>	
17. INFORMANT <u>John T. Squires</u>		Address <u>1642 Rickenbacker Road.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, transverse colon</u> 1531 DUE TO <u>c involvement of pancreas, mesentery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr + ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>8-15</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis A. Clark Jr</u>		22b. DATE SIGNED <u>3-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS A. CLARK, JR</u>		22d. ADDRESS <u>112. Chase Street.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Philip E. Cruch</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
ADDRESS <u>1211 Chesapeake Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 ho after death. Page 4
may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03362

03354

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>607 Reisters town Rd.</i>		d. STREET ADDRESS <i>607 Reisters town Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Theodore</i> Middle <i>S.</i> Last <i>Stansbury</i>		4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 29-1884</i>
9. AGE (In years lost birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>Theodore S. Stansbury, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Merryman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Howard S. Stansbury</i>		Address <i>10 Linden Terrage</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Infarction</i> 4201 DUE TO (b) <i>Coronary atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <i>Virus - pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-1-66</i> to <i>3-26-67</i> , 19____, that (I) (we) lost saw the deceased alive on <i>3-25-67</i> and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>James L. Saffell</i>		22b. DATE SIGNED <i>3-27-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES L. SAFFELL</i>		22d. ADDRESS <i>10 Main St Reisters town, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 29, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury</i>		25a. REC'D BY REGISTRAR <i>MAR 28 1967</i>	
ADDRESS <i>4411 Windsor Mill Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03380

CRIMINAL RECORD

03380

RECEIVED
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JAN 10 1964

CERTIFICATE OF DEATH

03355

03363

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>30.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agnes Women's Agnes Men's Homes</u>		d. STREET ADDRESS <u>2617 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>J. Virginia Strait</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 4, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>69</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fulmer</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frances M. Strickland</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>8 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>March 31, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 30</u> 19 <u>67</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>March 31, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>_____</u>		22d. ADDRESS <u>4-E-33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4/3/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gracelawn Mem. Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wilmington, Del.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Fulmer & Sons</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03327

CASE 20

52 02 April 1995

Wm. B. Smith

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

03364

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03356

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (White Hall)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (White Hall)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graystone Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lewis</u> Last <u>Stielper</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 8, 1894.</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Stielper</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmena Schilp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-4701</u>		17. INFORMANT <u>Mrs. Mary T. Stielper</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				22. DATE SIGNED <u>3/21/67</u>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>PARKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03365 CERTIFICATE OF DEATH 03357											
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson				c. LENGTH OF STAY IN b 161 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital						d. STREET ADDRESS 2038 Entaw Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tommie Lee Stokes			4. DATE OF DEATH Month Mar Day 9 Year 1967								
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-16		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Tommie Stokes				14. MOTHER'S MAIDEN NAME Abby Sanders							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 416-26-1996		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Tonsil. 1450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2021 Far Adv. Pul. Tuberculosis										INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-30 , 19 66 , to 3-9 , 19 67 , that (I) (we) last saw the deceased alive on 3-8 , 19 66 , and that death occurred at 3:20 A.M., from the causes and on the date stated above.											
22a. SIGNATURE W. Newcomer						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3-9-67		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent						22d. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School				23d. LOCATION (City, town or county) (State) BALTIMORE, Md.			
24. FUNERAL DIRECTOR Herrell Funeral Home						25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Baltimore County

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For the Pop. Tuberculosis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
03366					CERTIFICATE OF DEATH					03358				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 304 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 402 Radnor XXX. Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Sena Mabel Stone					4. DATE OF DEATH Month Day Year March 1, 19 67									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/86		9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days 19 67				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William N. Pearce					14. MOTHER'S MAIDEN NAME Mary Ann Griffin									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-32-6547B		17. INFORMANT Luther B. Stone			Address Above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO (b) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of the toe (great) right foot										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (1) (this hospital) attended the deceased from 2/21 , 19 67 , to 3/1 , 19 67 , that (A) (we) last saw the deceased alive on 3/1/67 , 19 67 , and that death occurred at 3:28M , from causes on and on the date stated above.														
22a. SIGNATURE Eduardo Canilang M.O. 22c. PHYSICIAN'S NAME (Type) Eduardo Canilang, M.D.										22b. OATE SIGNED 3-1-67 22d. ADDRESS 7620 York Road, Baltimore, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. OATE THEREOF 3-4-67		23c. NAME OF CEMETERY OR CREMATORY St. Marys Episcopal			23d. LOCATION (City or Town) (County) (State) Baltimore Md.						
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Baltimore						25a. REC'D BY REGISTRAR MAR 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge						

03358

DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03367

CERTIFICATE OF DEATH

03359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>3801 Labyrinth Road</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH STRAUSS</u>		4. DATE OF DEATH <u>March 19, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Milwaukee, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Fredman</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Richenbaum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Miriam Selznick</u>		Address <u>3801 Labyrinth Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>260X</u> IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> DUE TO (b) <u>distal embolus</u> DUE TO (c) <u>distal embolus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40</u> <u>40</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>3/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> 19 <u>67</u> and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Milton Kirsch</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Milton Kirsch</u>		22d. ADDRESS <u>4000 W. Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Springhill</u>	23d. LOCATION (City or Town) (County) (State) <u>Milwaukee, Wisconsin</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

03368

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coereville</u>		c. LENGTH OF STAY IN 15 <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Homes</u>		d. STREET ADDRESS <u>1925 Wilkins Ave</u>	
3. NAME OF DECEASED (Type or print) <u>MINNIE Elsie Stroh</u>		4. DATE OF DEATH <u>March 30 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1892</u> 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sale Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Balthaser Stroh</u>		14. MOTHER'S MAIDEN NAME <u>Marie Schmehl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-6337-5</u>	
17. INFORMANT <u>Records of Md. Masonic Home</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Generalized arteriosclerosis</u> DUE TO (b) <u>acute urinary tract obstruction</u> DUE TO (c) <u>and infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3 Cerebrovascular accident & Senility</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1965</u> to <u>March 30 1967</u> that (I) (we) last saw the deceased alive on <u>March 29 1967</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. Hamel MD</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED MD</u>		22d. ADDRESS <u>MASONIC HOME, Cockeysville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon, Baltimore</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Md.</u>	
24. FUNERAL DIRECTOR <u>Will. Cook-Brooks Towson,</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>Towson, Md. 21204</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03369

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03361

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD		c. LENGTH OF STAY IN 1b 95 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 2907 BOARMAN AVENUE	
3. NAME OF DECEASED (Type or print) First OLIVER Middle -- Last STROSNIDER		4. DATE OF DEATH Month MARCH Day 6 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 16, 1892
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) WARDENSVILLE, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL STROSNIDER		14. MOTHER'S MAIDEN NAME SUSAN KECKLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 212 18 38 09	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Fracture & dislocation Right hip - 5 1/2 mos DUE TO (c) Chronic Granuloma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Granuloma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9-18 19 66 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home		20f. City or town (County) (State) Balt. Md 21215	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) MELVIN B. DAVIS, M. D., 6800 MORNINGTON ROAD, BALTIMORE, MD. 21222		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/9/67	
23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Joseph N. Zannino		25a. REC'D BY REGISTRAR DATE MAR 9 1967	
25b. REGISTRAR'S SIGNATURE Joseph N. Zannino		25c. REGISTRAR'S SIGNATURE Joseph N. Zannino	

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THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE. THE INFORMATION IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03370
03362
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth2dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 6501 Regate Circle	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bridget Middle K. Last Sullivan		4. DATE OF DEATH Month March Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1887
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months 03-1 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Peter KELLY		14. MOTHER'S MAIDEN NAME Ellen HOARE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 073-12-4568D	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of parotid gland.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 27, 1967 , to 3/29, 1967 , that (I) (we) last saw the deceased alive on 3/29, 1967 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Narciso W. Charrona M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CHARRONA		22d. ADDRESS SPRING GROVE STATE HOSPITAL	
22e. ADDRESS Baltimore, Maryland 21228		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-1-1967	
23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTO. MARYLAND	
24. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE		25a. REC'D BY REGISTRAR MAR 31 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. REGISTRAR'S SIGNATURE	

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FOR STATE
HEALTH DEPT.

03371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03363

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			c. LENGTH OF STAY IN lb 43-1			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. Gen. Hosp.				d. STREET ADDRESS 3820 Cassandra Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Solomon Middle Lyon Last Taks				4. DATE OF DEATH Month Mar. Day 19 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Oct. 9, 1911	
				9. AGE (In years lost birthday) yrs. 55		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Flooring Bus.		11. BIRTHPLACE (State or foreign country) New York City, N. Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Phillip Taks				14. MOTHER'S MAIDEN NAME Hannah ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 113-12-5031		17. INFORMANT Mrs. Rebecca Taks, 3820 Cassandra Rd.,			
Address Randallstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED 3-20-67				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/21/67			
23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh Beth Israel				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.				25a. REC'D BY REGISTRAR MAR 22 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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REPUBLICAN PARTY - 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND									
03372 CERTIFICATE OF DEATH 03304									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>BALTIMORE</u> b. COUNTY <u>MARYLAND</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>56 GREATER BALTIMORE MEDICAL CENTER</u>					d. STREET ADDRESS <u>9 DUNKIRK ROAD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STELLA</u> First <u>OSING</u> Middle <u>Talbot</u> Last					4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/82</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE M LEWIS</u>					14. MOTHER'S MAIDEN NAME <u>CORA PRYOR</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-52-4671-1A</u>		17. INFORMANT <u>Mrs. John I. DeMoss</u>			Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral and Respiratory Arrest.</u> 4330 DUE TO (b) <u>Heart failure.</u> DUE TO (c) <u>Arteriosclerotic Cardio Vasc Disease.</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. LARRABEE</u>					22d. ADDRESS <u>G. B. N. C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home, Inc.</u> <u>6500 York Rd. Baltimore, Md. 21212</u>					25a. REC'D BY REGISTRAR <u>Charles Young</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>		

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Askerordhans Cade 188 2mcc
Heart failure
Chronic and Acute Heart

[Signature]
E. TABER

G. S. M. C.

3-23-07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03373

CERTIFICATE OF DEATH

03365

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Tb 9 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 424 N. Patterson Park Avenue	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle -- Last TAYLOR		4. DATE OF DEATH Month MARCH Day 29 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH [REDACTED]
9. AGE (In years last birthday) yrs. 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPREADER & CUTTER	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPREADER & CUTTER		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG. CO.	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (ROMERO BROS.) ABRAHAM TAYLOR		14. MOTHER'S MAIDEN NAME HURWITZ MINNIE [REDACTED]	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212 01 66 66	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE AND CEREBRAL ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 3/20/67 , 19__ to 3/29/67 , 19__, that he (we) last saw the deceased alive on 3/29/67 , 19__, and that death occurred at 4:35 AM from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE SIGNED 3/29/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/30/67	23c. NAME OF CEMETERY OR CREMATORY ANSHE NESINA	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON BROTHERS		25a. REC'D BY REGISTRAR APR 3 1967	25b. REGISTRAR'S SIGNATURE [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03374

CERTIFICATE OF DEATH

03366

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Patto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6625 Loch Raven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Tracey Taylor		4. DATE OF DEATH Month Day Year March 20, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1967
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months Days 5 49	11. IF UNDER 24 HRS. Hours Min. 5 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Insley, Raymond		14. MOTHER'S MAIDEN NAME Tracey, Kathleen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from March 20, 19 67 , to March 20, 1967 , that 10 (we) last saw the deceased alive on March 20, 19 67 , and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE Jose Aguto		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Jose Aguto, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-22-67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

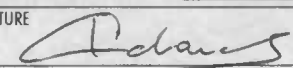
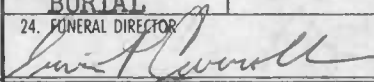

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03375

CERTIFICATE OF DEATH

03367

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 68 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 2139 N. SMALLWOOD STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK M. THOMAS		4. DATE OF DEATH Month Day Year MARCH 9 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1893
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WALTER		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE CLUB	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMAS		14. MOTHER'S MAIDEN NAME MARGARET SHEPPERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 215 07 09 20	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO COLIFORM BACTERIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CYSTITIS, CHRONIC		INTERVAL BETWEEN ONSET AND DEATH HOURS WEEKS WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ADENOCARCINOMA OF PROSTATE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/30/67 , 19__, to 3/9/67 , 19__, that (X) (we) last saw the deceased alive on 3/9/67 , 19__, and that death occurred at 12:35 PM , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR 		25a. REC'D BY REGISTRAR IRVIN P. CARROLL DATE MAR 13 1967	
25b. REGISTRAR'S SIGNATURE 			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03376

CERTIFICATE OF DEATH

03368

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>				d. STREET ADDRESS <u>603 Wildwood Parkway</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ann</u> Last <u>Tipman</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1885</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Fethe</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bardroff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Katherine Denbo</u> Address <u>2011 Woodlawn Dr. - 21207</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colon Rectal fistula</u> DUE TO (c) <u>Colostomy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>67</u> to <u>3/13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/13</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>D. P. Alagia</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. P. Alagia, M. D.</u>				22d. ADDRESS <u>3326 Frederick Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>				25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03370

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CERTIFICATE OF DEATH

State of New York
County of New York

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State of New York
County of New York

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State of New York
County of New York

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ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
03377		CERTIFICATE OF DEATH	
03369			
1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley View Apts. Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Nursing Home		d. STREET ADDRESS 7736 Greenway Terrace	
3. NAME OF DECEASED (Type or print) ELIZABETH B. TIPTON		4. DATE OF DEATH March 17, 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1886
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barrett		14. MOTHER'S MAIDEN NAME Elizabeth Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-1575	
17. INFORMANT John H. Hissey, 1311 Fidelity Bldg., Balto.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ape plexy DUE TO (b) Arterio-sclerosis DUE TO (c) 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1939 to 17 March 1967 that (I) (we) last saw the deceased alive on 17 March 1967 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Reier		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Charles H. Reier, M.D.		22d. ADDRESS 6701 York Road, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR MAR 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03378					03370					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		Baltimore			a. STATE		Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Towson			b. COUNTY		Baltimore			
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
402 Carolina Road					402 Carolina Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)			
First Middle Last Peter W. Traynor, Sr.					Month Day Year March 9 19 67		IF UNDER 1 YEAR IF UNDER 24 HRS.			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/8/1883		83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired-Engineer				Electrical		Kansas		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
John H. Traynor					Elizabeth Willoughby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No							Mrs. Ella D. Traynor (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 Carcinomatosis								1 yr		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of sigmoid										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 7, 1967, to March 9, 1967, that (I) (we) last saw the deceased alive on March 8, 1967, and that death occurred at 5:40 AM, from the causes and on the date stated above.										
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
Dr. Allan A. Spier					22d. ADDRESS		1501 Pentridge Road			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial					3/11/1967		Hillcrest Burial Park		Cumberland, Md.	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.					MAR 10 1967		Charles Judge			

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1st Floor

1st Floor

1st Floor

London

100 Grosvenor Road

100 Grosvenor Road

John I. Thompson

John I. Thompson

100 Grosvenor Road

100 Grosvenor Road

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03371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in the original papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN lb <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6835 BLENHEIM RD</u> d. STREET ADDRESS <u>6835 BLENHEIM</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AZILE</u> Middle <u>NMN</u> Last <u>TROUP</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/29/1892</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. BIRTHPLACE (County & State, or foreign country) <u>WILMINGTON N.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY HEWLETT</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BENDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-45-4145</u>	
17. INFORMANT <u>PATIENT CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>432X PNEUMOCOCCAL PERICARDITIS AND MYOCARDITIS WITH HEMORRHAGE AND TAMPONADE</u> (b) <u>AND TAMPONADE</u> (c) <u>PNEUMOCOCCAL BACTEREMIA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>SEPTICEMIA FROM PNEUMOCOCCAL ARTHRITIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 14</u> , 1967, to <u>March 18</u> , 1967, that (I) (we) last saw the deceased alive on <u>March 18</u> , 1967, and that death occurred at <u>3:40</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>M. Isabelle MacGregor</u>		22b. DATE SIGNED <u>3-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M-I. MAC GREGOR</u>		22d. ADDRESS <u>Gr. Baltimore Medical Centre</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Baltimore, Maryland 21212</u>		DATE <u>MAR 27 1967</u>	

03371

03370

RECEIVED

11/10/11

11/10/11

11/10/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03380					03372								
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Joppa d. STREET ADDRESS 2608 Mountain Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) New Marie First BERTHA Middle Uhlík Last Uhlík			4. DATE OF DEATH March 21 1967 Month March Day 21 Year 1967										
5. SEX F.		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-21-01		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress				10b. KIND OF BUSINESS OR INDUSTRY CLOTHING				11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia				12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Kadin Slav Pribovsky						14. MOTHER'S MAIDEN NAME Marie Josephik							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 213-10-3164		17. INFORMANT Records, Mt. Wilson State Hospital Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 170X DUE TO (b) ACUTE PYELITIS DUE TO (c) MEDULLARY CARCINOMA OF BREAST CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 16, 1967, to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21 1967 , and that death occurred at 10 P.M. from the causes and on the date stated above.													
22a. SIGNATURE W. Newcomer										22b. DATE SIGNED 3/22/67			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent										22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY BOHEMIAN NATIONAL			23d. LOCATION (City, town or county) (State) BALTIMORE MD					
24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR RD						25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

03300

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Mr. Newcomer, R.D., Superintendent, Mount Wilson, Maryland

03381

CERTIFICATE OF DEATH

03373

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN lb 1 wk. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 714 Greenwood Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Surity ULRICH				4. DATE OF DEATH Month March Day 12 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-97	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Mr. Casualty Co.		11. BIRTHPLACE (County & State, or foreign country) Id.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Urvich			14. MOTHER'S MAIDEN NAME Mary Shields				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-3754		17. INFORMANT Records, Mount Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Manic Hemoptysis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary tuberculosis DUE TO (c) concurrent (2-4 yrs)						INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-3-67 , to 3-4- , 19 67 that (I) (we) last saw the deceased alive on 3-11 19 67 , and that death occurred at 1145A , from causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 3-11-67		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Trinity Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Balt. Co. Md.	
24. FUNERAL DIRECTOR Howell Funeral Home				25a. REC'D BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03312

1860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03382

CERTIFICATE OF DEATH

03374

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT CONV. HOME</u>		d. STREET ADDRESS <u>26 NEWBURG AVE</u>	
3. NAME OF DECEASED (Type or print) <u>M. REGINA UPMAN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/77</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEC.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN B. UPMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN M. PATTERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212031591</u>	
17. INFORMANT <u>PAUL KAEHLER</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>Cerebral Vascular Thrombosis</u> (b) <u>Arteriosclerotic Cardiovascular Disease with chronic congestive Heart Failure.</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(3) Unrelieved Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2/27/67</u>	20f. (City or town) (County) (State) <u>3/1/67</u>
21. I certify that (I) (this hospital) attended the deceased from <u>2/28/67</u> to <u>3/1/67</u> , that (I) (was) last saw the deceased alive on <u>2/28/67</u> , and that death occurred at <u>1:54</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>W E McGrath MD</u>		22b. DATE SIGNED <u>3/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W E McGrath MD</u>		22d. ADDRESS <u>1303 Frederick Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>E. S. MALNAB</u>		25. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
ADDRESS <u>301 FREDERICK RD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1000 CALIFORNIA HIGHWAY 1000
MESA

STATE OF CALIFORNIA
COUNTY OF SAN DIEGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03383					03375				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Baltimore					Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Catonsville					Maryland Park, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. STREET ADDRESS				
SPRING GROVE STATE HOSPITAL					6412 East Street N.E.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Rebecca Vance					Month Day Year March 15 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
female		white				Sept. 30, 1882 84 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife						Virginia		U. S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Samuel VANCE					Eva SINGER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address				
			219-54-3454T		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4221 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated assoc. cerebral arterioscler. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (this hospital) attended the deceased from March 29 19 56 to March 15 19 67, that (we) last saw the deceased alive on March 15 19 67, and that death occurred at P. M, from the causes and on the date stated above. 22a. SIGNATURE [Signature] M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 22b. DATE SIGNED 3-16-67 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 3/18/67 23c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L 23d. LOCATION (City, town or county) (State) SCITLAND MD. 24. FUNERAL DIRECTOR W.L. Chambers Co. 577 1/2 St. ADDRESS WASH. D.C. 25a. REC'D BY REGISTRAR DATE MAR 20 1967 25b. REGISTRAR'S SIGNATURE [Signature]									

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence prior to admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWSON		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE GLOVER VANDERVEER		4. DATE OF DEATH Month MARCH Day 21st Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-03
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) LONG ISLAND N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. VANDERVEER		14. MOTHER'S MAIDEN NAME LOTTIE BAIRD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-1007	
17. INFORMANT MRS. MIRIAM B. VANDERVEER (SAME)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left bronchus. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 20, 1967 to March 21, 1967 that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 11:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Isabelle MacGregor		22b. DATE SIGNED 3-21-67	
22c. PHYSICIAN'S NAME (Type) ISABELLE MAC GREGOR		22d. ADDRESS Greater Baltimore Medical Centre	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/22/1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 23 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (P)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03377

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore 21204	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 809 Shelley Road	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last VERRIER		4. DATE OF DEATH Month March Day 27 Year 19 67.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1902.
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 27 Days 19 Hours 67.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Balto. County	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Verrie		14. MOTHER'S MAIDEN NAME Lucinda Gauthier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-12-3308	
17. INFORMANT Mrs. Mary Sabella		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Ulceroate Bronchitis (b) Bronchial Pneumonia DUE TO 48K (c) 48K Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 48K
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4/3/67.	23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 4/28/67	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03386

CERTIFICATE OF DEATH

03386

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 63 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21217		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 585 PRESSMAN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle -- Last WADE		4. DATE OF DEATH Month MARCH Day 29 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 1, 1909
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN		10b. KIND OF BUSINESS OR INDUSTRY CARPET COMPANY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY WADE		14. MOTHER'S MAIDEN NAME FLORENCE WASHINGTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 10 55 80	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT UPPER LOBE DUE TO (b) ATELECTASIS AND INFARCTION OF RIGHT LOWER LOBE, RT LUNG DUE TO (c) BRONCHOPNEUMONIA PULMONARY EDEMA AND CONGESTION OF LEFT LUNG 1621		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/25/67 , 19 67 , to 3/29/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/29/67 , 19 67 , and that death occurred at 2:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 3/29/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-3-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Kelson Funeral Home</i>		25a. REC'D BY REGISTRAR APR 3 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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CERTIFICATE OF DEATH

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03379

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY —			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore # 21224 . 30-4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney - Towson Nursing Home				d. STREET ADDRESS 643 S. Oldham St.			
3. NAME OF DECEASED (Type or print) First ROSE Middle A. Last WALLNER				4. DATE OF DEATH Month March Day 27 Year 1967.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1889	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Rehak				14. MOTHER'S MAIDEN NAME Maria ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. —		17. INFORMANT John J. Wallner Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Congestive Heart Failure DUE TO (b) Pulmonary Embolus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 7 weeks 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/1/67 9:40 P.M. 3/27/67 , that (I) (we) last saw the deceased alive on 3/27 1967 , and that death occurred at — M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph A. Sedlaack				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/28/67	
22c. PHYSICIAN'S NAME (Type) Joseph A. Sedlaack				22d. ADDRESS 200 W. Pennsylvania Ave., Towson, 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-30-67.		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City, town or county) (State) 7401 German Hill Rd., Ba. Co., M	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler				25. RECEIVED BY REGISTRAR Mar 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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643 E. Oregon St.

Bellevue - Oregon Building House

Bellevue

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John J. Bellevue

500 N. Pennsylvania Ave., Portland, O.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G386 3/8/67 pc
Item #3 Film #G386 3/14/67 pc

03388

CERTIFICATE OF DEATH

03380

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>30-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		d. STREET ADDRESS <u>414 Rosecroft Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Kerdock</u> Middle <u>Vera / Valunas (Valunas)</u> Last <u>March</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lithuanian</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Govelis</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>21 6 09 7218</u>	
17. INFORMANT <u>Daniel Kerdock</u>		Address <u>402 Rosecroft Terrace</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Pulmonary edema</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>C.S. Congestive heart failure.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>March 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 3 1967</u> , and that death occurred at <u>2 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Ankudas</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley Ankudas, M.D.</u>		22d. ADDRESS <u>1101 Maiden Choice Lane #21229</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltore Md</u>	
24. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc 1600 Hollins St</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 3 1967</u>	

03388

DEPARTMENT OF HEALTH

03388

Name of Patient		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Address		City		State		Zip	
Name of Physician		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	
Name of Nurse		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	
Name of Doctor		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	
Name of Patient		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Address		City		State		Zip	
Name of Physician		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	
Name of Nurse		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	
Name of Doctor		Date of Admission		Date of Discharge		Date of Death		Cause of Death		Place of Death		Hospital		Room		Bed		Ward		Floor	

THIS IS A COPY OF THE ORIGINAL RECORD OF THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03381	
03389				CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. STREET ADDRESS 3368 Dulaney Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM WARD		4. DATE OF DEATH Month March , Day 8 , Year 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-21-1892		9. AGE (In years and months) 74 yrs.		IF UNDER 1 YEAR: Months 19 , Days 67 , Hours 19 , Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Ward		14. MOTHER'S MAIDEN NAME Delia Lagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Regina L. Ward, 3368 Dulaney St. 29	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 Cerebral Thrombosis Multiple DUE TO (b) Gangrene left distal leg & foot DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 months 4 days 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubiti Multiple		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/16/67 to 3/8/67 , that (I) (we) saw the deceased alive on 3/7/67 , and that death occurred at 6:20 A.M. from causes and on the date stated above.		22a. SIGNATURE Dr. W.E. McGrath		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. W.E. McGrath		22d. ADDRESS 1303 Frederick Road, Balto., Md. 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-11-1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

03381

CERTIFICATE OF DEATH

03380

Name of Deceased		Date of Death	
John Doe		1912-12-25	
Age		35	
Sex		Male	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

[Faint, illegible text and signatures, possibly bleed-through from the reverse side of the document.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21207</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2605 Gwynndale Ave. 21207</u>		d. STREET ADDRESS <u>2605 Gwynndale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elnora Wells</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/83</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mildred Ritchie - 1454 Jefferson St</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Arterio-Sclerotic Cardio-Vascular Disease</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James N. Frederick</u> M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>James N. Frederick</u>		Address (Street, city, town, or county)	
23a. 8 BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR <u>ELLsworth Armacost - 4600 Liberty Hgts Ave</u>		25a. REC'D BY REGISTRAR DATE <u>APR 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

033328

13331



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03330

CERTIFICATE OF DEATH

03382

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN lb Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2356 Research Avenue		d. STREET ADDRESS 2356 Research Avenue	
3. NAME OF DECEASED (Type or print) CHARLES GRAYSON WELDEN		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1925
9. AGE (In years lost birthday) yrs. 41		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles A. Welden	
14. MOTHER'S MAIDEN NAME Florence Thorn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 212-20-5366		17. INFORMANT Mrs. Dorothy M. Weldon, 2356 Research Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO General Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/7 , 19 55 , to 3/8 , 19 67 , that (I) (we) last saw the deceased alive on 3/6 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE Edmund W. Johnson		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. E.W. Johnson		22d. ADDRESS 3432 Frederick Avenue, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-10-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR MAR 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03392

CERTIFICATE OF DEATH

03384

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 11 days		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2204 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE JAMES WILLIAMS				4. DATE OF DEATH Month Day Year March 12 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/19		9. AGE (In years lost birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Piano Company		11. BIRTHPLACE (County & State, or foreign country) Jonesville, S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Williams				14. MOTHER'S MAIDEN NAME Ethel Durant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 250 18 19 64		17. INFORMANT Address Clinical Rcds. VA Hospital, Ft Howard Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT LATERAL VENTRICAL DUE TO (b) -- DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) LAENNEC'S CIRRHOSIS (FATTY LIVER) CHRONIC ALCOHOLISM							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from March 1 , 19 67 , to March 12 , 19 67 , that (X) (we) last saw the deceased alive on March 12 , 19 67 , and that death occurred at 11:30 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Neilson Neilson</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.				22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3055 W. North Ave. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAR 14 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

03382

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #4387 3/30/67 bc

03393

CERTIFICATE OF DEATH

03385

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BELAIR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 2 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE		e. STREET ADDRESS Rt. 4 WESTMINSTER, MD 21157	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER CASSLE WIMERT.		4. DATE OF DEATH Month Day Year MARCH 22 19 67.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8. 23. 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON AND BRICK LAYER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CARROLL COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL WIMERT		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-05-6220	
17. INFORMANT PATIENT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Congestive heart failure. DUE TO (b) Acute myocardial infarction. DUE TO (c) 2 days.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 21, 19 67 , to March 22, 19 67 , that (I) (we) last saw the deceased alive on March 22, 19 67 , and that death occurred at 1:00 P.M. , from causes and on the date stated above.			
22a. SIGNATURE M. Isabelle MacGregor M.D.		22b. DATE SIGNED 3-22-67.	
22c. PHYSICIAN'S NAME (Type) M. ISABELLE MACGREGOR		22d. ADDRESS Greater Baltimore Medical Centre.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/25/67	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery	23d. LOCATION (City or Town) (County) (State) Westminster Carroll Co. Md.
24. FUNERAL DIRECTOR J. S. Myers, Westminster, Md.		25. REGISTRAR MAR 21 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03389

03389

218-00000 PATENT CASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

03394

CERTIFICATE OF DEATH

03387

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 103-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks 21152, Rt. 1. d. STREET ADDRESS 03-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry ZANDER		4. DATE OF DEATH Month Day Year March 16, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/06
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Gas & Electric Co.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonard W. Zander		14. MOTHER'S MAIDEN NAME Fannie Seidhoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-4680	
17. INFORMANT Mrs. Emma J. Zander		Address Sparks, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4201 DUE TO (b) Myocardial Infarction DUE TO (c) Pulmonary Thrombo-embolism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Thrombo-embolism		INTERVAL BETWEEN ONSET AND DEATH 4201	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. Reynaldo Orjuela-Gomez (this hospital) attended the deceased from March 3, 1967 , to March 16, 1967 , that (X) (we) last saw the deceased alive on March 16, 1967 , and that death occurred at 9:05 M. from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE-THEREOF 3/18/67	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City or Town) (County) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
25. PREPARED BY REGISTRAR Charles Judge		26. REGISTRAR'S SIGNATURE Charles Judge	

03330

REPUBLIC OF CHINA

03330

San Francisco

October 21, 1954

To: Honorable Mr. [Name]

Dear Sir:

Reference is made to your letter of [Date]

concerning [Subject]

It is noted that you are [Action]

and are [Action]

Very truly yours,

[Signature]

[Stamp]

Very truly yours,

[Signature]

Very truly yours,

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03395

CERTIFICATE OF DEATH

03388

1. PLACE OF DEATH a. COUNTY BALTO. County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. Co		c. LENGTH OF STAY IN 1b 19 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1727 LYNCH Rd.		d. STREET ADDRESS 1727 LYNCH Rd.	
3. NAME OF DECEASED (Type or print) RT. REV. THOMAS B. ZINKAND		4. DATE OF DEATH Month MARCH Day 7 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RC. CLERGYMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK ZINKAND		14. MOTHER'S MAIDEN NAME MARY E. HERRON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT SISTER Address SISTER MARY THOMAS MERCY HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO interocoronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 7 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19__, to 3/7/67 , 19__, that (I) (we) last saw the deceased alive on 3-1-1967 , and that death occurred at 11A.M. from causes and on the date stated above.			
22a. SIGNATURE S. Edwin Muller		22b. DATE SIGNED 3/8/67	
22c. PHYSICIAN'S NAME (Type) S. EDWIN MULLER		22d. ADDRESS 1203 ST Paul St Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-11-1967	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City or Town) (County) (State) BALTO., MD
24. FUNERAL DIRECTOR J. Stated Conklin ADDRESS 5444 BELAIR Rd.		25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE J. Stated Conklin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICE OF THE

UNITED STATES

DEPARTMENT OF

THE TREASURY

WASHINGTON

OFFICE OF THE

COMMISSIONER OF

INTERNAL REVENUE

WASHINGTON

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